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C. R.—Case Report (Clinical Notes).
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*stimulation
of labor*

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*This nationwide survey was sponsored by Sharp & Dohme to make available to physicians accurate figures on the extent to which mothers utilize immunization benefits.

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Diphtheria									
Schick Test									
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2404 Broadway, Oakland
President, Safford A. Jelte, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
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Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
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Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

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Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

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President, Max J. Goodman, 525 7th Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
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Secretary, F. Powers-Heald, 107 So. 5th Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
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Secretary, Joseph W. Telford, Bishop.
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Kern County Medical Society
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Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
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Kings County Medical Society
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Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
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Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
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Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

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President, Edward A. Macklin, P.O. Box 176, Kelseyville.
Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

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Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Winton F. Swengel, 499 Pacific Street, Monterey.
Secretary, Raymond V. Rukke, 135 Franklin Street, Monterey.
Meeting, *First Thursday.*

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Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

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Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
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Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

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President, Raymond L. Johnson, Corona.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweil, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, John W. Cline, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Deon A. Crew, 748 Marsh Street, San Luis Obispo.
Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder, 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. A. Shufelt, 241 E. Santa Clara Street, San Jose.
Secretary, Leon P. Fox, Sainte Claire Building, San Jose.

Santa Cruz County Medical Society
President, M. D. McPherson, Vine and Church Streets, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Monday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Julius M. Kehoe, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, R. L. Zieber, 838 Fourth Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, H. B. Stewart, 1409 H Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
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Secretary, O. T. Wood, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
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Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
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Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
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Secretary, Austin M. Clark, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

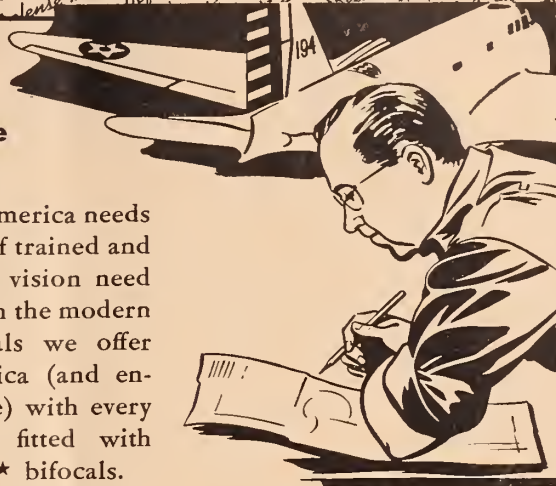
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(Continued from Page 3)

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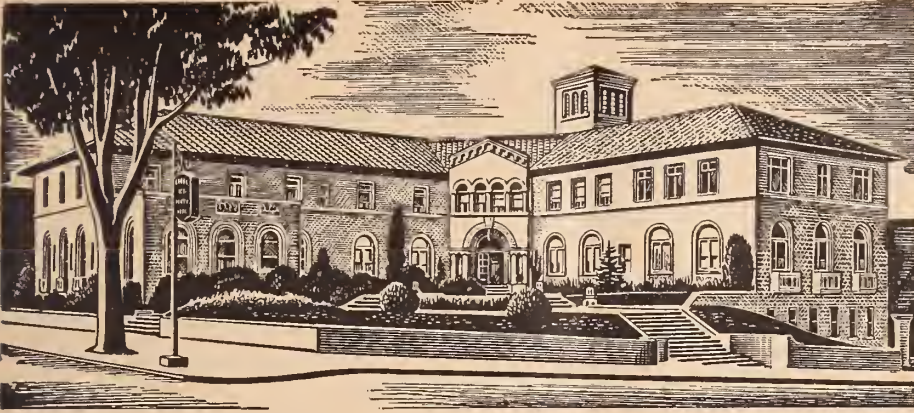
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 Medicine; Attending Pediatrician, Illinois Research and
 Educational Hospital, Cooke County and Michael Reese
 Hospitals, and Evelyn C. Lundeen, R. N., Supervisor,
 Premature Infant Station, Sarah Morris Hospital, Chi-
 cago. Cloth. Price, \$3.50. Pp. 309, with 74 illustrations.
 Philadelphia: J. B. Lippincott Company, 1941.

This book is without doubt the most complete treat-
 ment on the premature infant which has yet appeared in
 English literature. Its greatest value and significance lies
 in the fact that it is not primarily a review of the ex-
 perience of others, but rather is based upon Dr. Hess'
 many years of experience and study of the premature
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 and there are individual chapters on all of the diseases
 of early infancy. Furthermore the book is replete with
 clear illustrations, charts, suggested forms for recording
 essential data, and outlines of proper nursing technique.
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(Continued on Page 10)

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BOOK REVIEWS

(Continued from Page 7)

Every ward where premature infants are kept, every pediatrician's library, every nursing school library and general medical library should have this volume.

WM. C. BLACK, M. D.

Roentgen Treatment of Infections. By James F. Kelly, M. D., F.A.C.R., Professor and Director of the Department of Radiology, Creighton University School of Medicine; Attending Radiologist, Creighton Memorial St. Joseph's Hospital, St. Catherine's Hospital and Douglas County Hospital, Omaha, and Mercy Hospital, Council Bluffs, Iowa, and D. Arnold Dowell, M. D., Assistant Professor of Radiology, Creighton University School of Medicine; Assistant Attending Radiologist, Creighton Memorial St. Joseph's Hospital, St. Catherine's Hospital and Douglas County Hospital, Omaha, and Mercy Hospital, Council Bluffs, Iowa. Cloth. Price, \$6.00. Pp. 432, with 122 illustrations. Chicago: The Year Book Publishers, Inc., 1942.

This monograph is of special interest because of the subject which it covers, and the time at which it appears. The authors have selected for discussion infections which have had far too little attention in the past.

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(Continued on Page 14)

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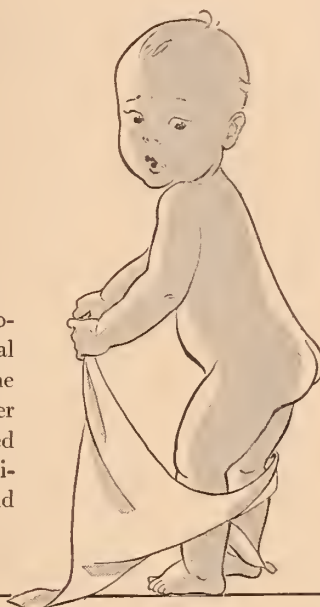
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BOOK REVIEWS

(Continued from Page 10)

methods discussed are supported by case studies and clinical charts in profusion.

The last chapter, discussing contraindications to the use of x-ray, should be read by every one who does radiotherapy for, even though we feel we know all of the limitations of x-ray, it will impress us with the fact that there are some things we have overlooked.

J. C. H., JR., M. D.

Management of the Sick Infant and Child. By Langley Porter, B. S., M. D. M. R. C. S. (Eng.), L. R. C. P. (Lond.), Dean Emeritus, University of California Medical School and Professor of Medicine; Formerly Professor of Clinical Pediatrics, University of California Medical School; Formerly Visiting Pediatrician, San Francisco Children's Hospital; Formerly Member Health Advisory Board of the City and County of San Francisco, and William E. Carter, M. D., Director of University of California Hospital, Out-Patient Department; Formerly Chief of Children's Clinic, University of California Hospital; Formerly Attending Physician, Los Angeles County Hospital; Formerly Attending Physician, San Francisco Hospital, San Francisco. Sixth Revised Edition. Cloth. Pp. 977. St. Louis: The C. V. Mosby Company, 1942.

This edition reveals the amazing advances of pediatric thought and practice since the first edition in 1922—in the days before insulin, vitamin and proven deficiency diseases, the sulfonamides, just to mention a few of the miraculous advances.

There is a splendid chapter on behavior, that is new and is to be commended highly. The section on eczema offers a long list of medicaments—about thirty in a confusing array. The first edition offered about seven—and this reviewer agrees that the treatment of eczema today

(Continued on Page 16)

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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BOOK REVIEWS

(Continued from Page 14)

doesn't seem much superior to that of the 1922 edition. The publishers have produced an excellent book in the way of binding, type and illustrations.

Night of Flame. By Dyson Carter. Cloth. Price, \$2.50. Pp. 337. New York: Reynall and Hitchcock, Inc.

According to the Publishers:

"Here is a pageant of a great hospital wherein the drama of life—and death—is played at high tension. 'Night of Flame' gathers up the whole of that small world and puts it under a microscope, in a story that is distinctive in its authentic background and the tautness of its telling."

According to the Reviewer:

This book contains three hundred and thirty-seven pages in which an effort is made to portray the atmosphere of a large general hospital. The commonness, sordidness and cheapness of the leading characters, and the feeble and deficient description of the life in and around a large hospital, cannot do other than shock the reader, especially if he be a physician. It would be interesting to know where the author, an engineer by training, picked up the half-baked and inaccurate concepts, which he has striven to incorporate in a novel. If you wish to squander money, here is an opportunity.

Synopsis of Materia Medica, Toxicology, and Pharmacology. By Forrest Ramon Davison, B.A., M.Sc., Ph.D., M.B., Medical Department, The Upjohn Co., Kalamazoo, Mich. Formerly Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Little Rock. Second Edition. For students and practitioners of medicine. The C. V. Mosby Company, 1942.

(Continued on Page 17)

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BOOK REVIEWS

(Continued from Page 16)

The writer states he has kept in mind two guiding principles: First, that pharmacology is an integral part of medicine; obviously, the theoretical study of drugs should not be divorced from the practical application. Second, there should be a judicious limitation of the subject matter consistent with its importance in the field of medicine. He has selected for discussion those commonly-used drugs with established effectiveness, eliminating superfluous material.

Hughes' Practice of Medicine. Revised and edited by Burgess Gordon, M. D., Clinical Professor of Medicine, Jefferson Medical College; Director and Physician-in-Charge, Department for Diseases of the Chest, Jefferson Hospital; Assistant Physician, Jefferson Hospital; Physician, Pennsylvania Hospital; Visiting Physician, the White Haven Sanatorium; Consultant in Tuberculosis, Philadelphia State Hospital; Consulting Physician, Frederick Douglass Memorial Hospital; Lieutenant Colonel, Medical Reserve, Base Hospital No. 33, with Sections on "Nervous and Mental Diseases," by Harold D. Palmer, M. D., and on "Diseases of the Skin," by Vaughn C. Garner, M. D. Contributors: "Sections on Clinical Methods," by Robert Charr, M. D., "Articles on Endocrinology," by Abraham E. Rakoff, M. D., and "Legal Aspects of Medicine," by Louis M. Stevens, Esq. Sixteenth Edition. The Blakiston Company, 1942. Price, \$5.75.

Hughes' Practice of Medicine has gone through sixteen editions, the present printing having been brought out under the editorship of Dr. Burgess Gordon. Included are discussions of newly-recognized entities and methods of treatment, particularly in respect to chemotherapy, vitamin therapy and endocrinotherapy.

The book is gotten up to present in concise form the clinical features and treatment of disease. New material

on the infections, chemotherapy and endocrinotherapy all receive attention in the present edition.

Elimination Diets and the Patient's Allergies. A Handbook of Allergy. By Albert H. Rowe, M. D., Lecturer in Medicine, University of California Medical School, San Francisco, California; Consultant in Allergic Diseases, Alameda County Hospital, Oakland, California. Lea & Febiger, 1941. Price, \$3.00.

Diet trials are given special consideration, the author's elimination diets being considered in considerable detail. Advantages of cereal-free diets are emphasized. Fruit-free and other elimination diets for special and routine study are not omitted. Menus are presented in considerable detail. Causation, diagnosis and control of various allergies are discussed.

Pronunciation of Sulfanilamide.—The recommendation of the Committee on Nomenclature of the Council on Pharmacy and Chemistry of the American Medical Association regarding the pronunciation of the words amide, sulfanilamide and sulfathiazole has been accepted by the Council, it reports in *The Journal* of the Association.

The Council reports that "the committee recommended that the word amide be pronounced with a long 'i' (amide), this being preferable both because of the final e and the analogy with chloride and iodide. For the same reason the committee held that the preferred pronunciation of sulfanilamide should be sulfanilamide with the major accent on the antepenultimate syllable, i'l'.

"In agreement with the principle that English accentuation is recessive, it is believed that the preferred accent would be on the syllable thi in sulfathiazole."

It is explained that these pronunciations are in harmony with those recommended by the American Chemical Society.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 58)

Thirdly, these documents record in unmistakable language that no matter how devoid of merit such a claim may be, no matter how outrageous or ridiculous its assumed basis in fact or theory, a very high degree of legal skill, a vast amount of work and vigilance, are frequently necessary to protect the property, and preserve the name and reputation of an able, skilful and devoted member of the profession.

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Subscriptions to the Fund are coming in. The Council has determined that until December 31, 1917, the amount shall remain the same, viz.: \$15 in cash and \$15 by note. We undertake to say that this is the best investment of \$30 that any member could make.

Insurance and the Indemnity Defense Fund.—When the Legal Defense Department was first instituted in 1909, no distinction was made as to the defense of members accused of malpractice, between members who were protected by corporate insurance and members who were not. In 1912 the constantly increasing cost of maintaining the Department caused the Council to adopt the rule that if a member were insured, he must elect whether or not he desired the insurance company or the Society to undertake his defense. . . .

Military Medical Needs.—There has been a great response to the initial calls for physicians in the Army and Navy Medical Corps, and the Medical Officers' Reserve Corps. And yet the need is so great that the real demand is still most inadequately met. . . .

Thus far there has been proportionately a much larger enrollment among the older physicians than among the younger. And yet no physician who has graduated within the last four years should content himself with other than the most substantial reasons against enrollment. In the military service, the younger officer has an immense advantage. If he enters the regular medical corps of army or navy, this advantage is peculiarly great as his order of seniority rises.

The Provocative Wassermann Reaction.—The value of the Wassermann test in helping make a diagnosis of syphilis is universally recognized; but the usefulness of the "provocative Wassermann" is not so well known. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "A Non-Suture Ocular Tendon Shortening With Results of Forty Operations," by Rod-eric O'Connor, M. D., Oakland, California.—At first thought one is apt to jump to the conclusion that, like the countryman looking at a giraffe for the first time, "there ain't no sich thing" possible. However, the thing is so simple the wonder is that it was not thought of long ago.

The idea came to me one day, when I was shortening a saddle girth, that an ocular tendon could be shortened in exactly the same way by dividing it into several bands. In this way a safe, and certain shortening, can be secured, without the constriction and cutting that is a necessary part of every suture method. It then becomes merely a question of sufficient experience upon which to base an estimate of the amount of shortening needed in any given case. This, because a definite shortening of the

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

inelastic tendon does not mean the same in the total
muscle, due to the elasticity of the muscle tissue. . .

From an Article on "Glaucoma; A Critical Survey of
Present Methods of Treatment," by Hans Barkan, M. D.,
San Francisco.—The present methods of treating glau-
coma can be divided into three classes: a well-defined
medical one, the treatment by means of myotics; a well-
defined surgical one, the classic iridectomy of Von
Graefe; an ill-defined surgical one, the principle of which
is to obtain a permanently-filtering fistula of the eyeball;
a certain hygienic and medical supervision and treatment
are applied to all these groups and count no more in the
results obtained in one than in the other. This paper
will take up these groups in the order mentioned. . .

From an Article on "The Early Surgical Treatment
of Squint," by Vard H. Hulen, A.M., M.D., F.A.C.S.,
San Francisco.—For many years the importance of be-
ginning the treatment of squinting children as soon as
the diagnosis can be made has been recognized. To Claud
Worth great credit must be given for the prominence and
importance of the early development of vision, and
fusion faculty in cross-eyed infants. Much good has been
accomplished by the early nonsurgical treatment advoca-
ted; but I believe it a mistake, when squint cases are
not thus cured, to postpone the surgical treatment until
the patient has passed the age of six or seven years, as
has been rather generally advocated. . .

(Continued in Back Advertising Section, Page 24)

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Annual Hospital Survey Shows Their Increasing Efficiency.—The constantly increasing efficiency of hospitals in this country is revealed in the twenty-first annual census of hospitals by the Council on Medical Education and Hospitals of the American Medical Association. The census shows that "The average stay per patient in general hospitals has been reduced from fourteen days in 1935 to twelve days in 1941, an average saving of two days per patient. For all the 10,646,947 patients in general hospitals in 1941 the aggregate saving was 58,339 years. Figuring this saving at \$4 a day, the cost of hospitalization for each patient admitted was \$8 less than it would have been in 1935, the equivalent of a saving of \$85,175,576 in hospitalization costs."

During the period from 1935 through 1941 the length of stay in governmental general hospitals dropped from twenty-two to eighteen days and in nongovernmental general hospitals from eleven to ten days. In general hospitals operated under federal auspices a reduction from thirty-six to twenty-one days was made, in those under state auspices from twenty-one to eighteen days, in county hospitals from twenty to eighteen days, in city hospitals from sixteen to fifteen days and in city-county hospitals from seventeen to twelve days. In church related hospitals the average stay dropped from twelve to ten days in the same period and in all non-profit association hospitals from eleven to ten days. In hospitals operated and owned by individuals and partnerships the rate remained stationary at eight days. In those operated by corporations for profit it dropped from nine to eight days.

The census discloses a total of 6,358 registered hospitals, an increase of 67 over the number on the Register one year ago. The growth of hospital facilities for the past year was the equivalent of one 269 bed hospital for every day, Sundays and holidays included.

The capacity of registered hospitals amounts to 1,324,381 beds and 66,163 bassinets. There are 98,136 more beds and 4,224 more bassinets than one year ago.

An editorial in the same issue of *The Journal* points out that "the data submitted suggest that the hospitals of this country have never been in better position to meet successfully such demands as may be made."

It is revealed by the census that during the year 11,596,188 patients entered registered hospitals as compared with 10,087,548 in 1940, an increase of 14.95 per cent. This means that patients entered hospitals at the rate of one for each 2.7 seconds day and night throughout 1941, including Sundays and holidays.

The average census of patients in hospitals was 1,087,039, an increase of 60,868 over the previous year. The average occupancy rate in general hospitals was 68.2 per cent compared with 70.3 per cent for the preceding year and the average number of idle beds in general hospitals for 1941 was 169,884, compared with 137,200 in 1940. The occupancy rate of all registered hospitals was 82.1 per cent for 1941 as compared with 83.7 per cent for 1940. However, it is pointed out in the report that "although there was a large increase in number of patients admitted to hospitals during the year, it does not necessarily follow that the rate of occupancy would be higher. Indeed, it appears that because of the rapid turnover of patients—that is, the shorter stay per patient—the rate of occupancy is not much greater than in previous years. . . ."

One person for each 11 in the United States entered a hospital as a patient in the year 1941, using the 1940 census and counting only bed patients.

The report points out that the list of registered hospitals omits additions to hospital facilities that may have been made by certain departments of the federal govern-

(Continued on Advertising Page 36)

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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 57

JULY, 1942

NO. 1

California and Western Medicine

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Four Fifty Sutter, Room 2004, San Francisco,
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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR GEORGE H. KRESS

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F. Burton Jones Vallejo 1944
Francis E. Toomey San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER JOHN HUNTON
Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

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Subscription prices, \$5 (\$6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

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EDITORIALS†

CALIFORNIA'S MEDICAL QUOTA FOR ARMED FORCES: FEDERAL SECURITY ADMINISTRATOR McNUTT'S REMARKS AT A.M.A. SESSION

Press Dispatches Concerning Administrator McNutt's Speech.—At the Atlantic City session of the American Medical Association on Monday evening, June 8th, and again on Tuesday morning, Hon. Paul V. McNutt, Federal Security Administrator—appointed by President Roosevelt as Director of the U. S. Office of Defense, Health, and Welfare Services—appeared before the A.M.A. House of Delegates, and his remarks received national publicity through the press associations. After perusal of some of the dispatches, a considerable number of physicians felt aggrieved, forgetting probably, that what was especially irritating was not so much what Mr. McNutt said but, rather, the headlines employed by local editors to introduce his comments. The remarks made by Administrator McNutt, as head of the Federal Procurement and Assignment Service, appeared in the *Journal of the American Medical Association* of June 20th, and physicians who are interested should take time to read what he there stated concerning Army, industrial and civilian medical-needs. His statement, "The Army and Navy and war industry areas have not gotten the doctors they need," may be said in a few words to have formed the basis of his other remarks, and should and will be pondered by all citizen groups, physicians included.*

* * *

A Telegram to Major Seeley, Executive Officer.—The editor was among those present at Atlantic City and heard Mr. McNutt's speeches; and in order to make certain that he had not misunderstood some of the figures presented by Mr. McNutt and his representatives, the following wire was sent to Major Sam F. Seeley, Executive Officer of the Federal Procurement and Assignment Service:

(Copy of Telegram)

WESTERN UNION

June 19, 1942.

Major Sam F. Seeley,
601 Pennsylvania Avenue, N.W.,
Washington, D. C.

To emphasize Mr. McNutt's Atlantic City re-

* For some press clippings, see in this issue, on page 97.

marks, we need following information. One, total number of California physicians now in active service in Army. Two, total number of California physicians still needed to meet California's quota at present date. Three, total number of additional California physicians needed for Army by December 31, 1942. Four, average number of California physicians who should enroll each month to permit California to fulfill its quota by December 31, 1942. Kindly send above or related figures.

(Signed) CALIFORNIA AND
WESTERN MEDICINE,

By: GEORGE H. KRESS, Editor,
450 Sutter, San Francisco.

* * *

Illuminating Reply Concerning California's Quotas.—In reply to this telegram of June 19th, a letter dated June 20th, was received, and that letter appears in its original form on another page in this issue.†† However, as printed below it has been changed by the editor, through additional paragraphs and numberings for greater convenience in reference and in the comments which are made thereon. Major Seeley's reply follows:

(COPY*)

Office for Emergency Management

WAR MANPOWER COMMISSION

Washington, D. C.

Chairman, Paul V. McNutt
Federal Security Administrator

Procurement and Assignment Service for
Physicians, Dentists and Veterinarians

June 20, 1942.

Dr. George H. Kress, Editor,
CALIFORNIA AND WESTERN MEDICINE,
450 Sutter Street,
San Francisco, California.

Dear Dr. Kress:

(1) In response to your telegram of June 19, the following round figures should be used as a basis for your calling to the attention of the medical profession of California the necessity of their early participation in the war effort.

(2) California's quota, in addition to interns and residents, is 2600, to be filled by December 31, 1942.

(3) Figures in this office indicate that less than 1000 are now in military service and your quota for the balance of the year is to be not less than 1800.

(4) Dr. Harold A. Fletcher, 490 Post Street, San Francisco, and Dr. Edward M. Palette, 1930 Wilshire Boulevard, Los Angeles, are responsible

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

†† See page 91 for original letter.

* (Paragraphing and numbers inserted by Editor for convenience in reference.)

as our State Chairmen for Physicians in California, to determine the availability of physicians in that State.

(5) I would emphasize that the majority of physicians of military age—i.e., those under 45, must anticipate military service sooner or later, except in proven instances where they cannot be spared from civil life.

(6) In the majority of the instances, the deferment of a man under 45 can only be considered temporary, and wherever necessary a replacement should be obtained from among those over 45, the women physicians, or those under 45 who have been rejected for military service.

(7) It is the opinion of this office that more than one-half of California's quota must be filled within the next sixty days and that a minimum of 1800 must enter the military service without fail.

(8) Since the question of dependency has practically been eliminated under Selective Service opinions, the remaining cause for deferment is occupational. In those cases where this office considers a man to be available, we feel justified in challenging deferment on an occupational basis. We do not want to have to resort to such a challenge.

(9) We look to the patriotism and enthusiasm of the medical personnel in California to meet this demand on a voluntary basis, and have set July 1, 1942, as the date to which we look forward when an appraisal of the situation will be carefully considered by the Directing Board in determining its future policies.

Sincerely yours,

(Signed) SAM F. SEELEY, M. D.,

Executive Officer,

Procurement and Assignment Service.

Major Seeley's Letter of June 20th should be Read by Every California Physician.—It is to be hoped that every member of the California Medical Association will take time to read Major Seeley's important communication, since he is the Executive Officer of the Federal Procurement and Assignment Service. If perused in conjunction with Mr. McNutt's speech, and also the report of the A.M.A. Committee on Medical Preparedness,* made through its chairman, Ex-president Irvin Abel, it is particularly illuminating as to military and related needs.

* * *

United States Statistics Concerning Available Medical Personnel.—To be in a position better to evaluate the medical problems now facing both the Government and the Medical Profession, it may be in order first to glance at some statistics dealing with the distribution of Doctors of Medicine in the United States, and in California.

Of some 180,000 licensed physicians in the United States at the present time, about 160,000

are in active practice. Classified according to age, in round numbers about 43,000 of this active group are under 36, while some 38,000 come within the age group, 36 to 44 years. These two classes make a total of about 81,000 Doctors of Medicine who belong to the age-groups from which the personnel of the Armed Services, in greatest part, must be supplied. Of course, all physicians in the up-to-45 group are not available for medical service, because some have physical disabilities, and others are in essential industries or possess other deferment requisites.

* * *

Figures for the State of California.—Referring now to California statistics, there is a total of 12,868 physicians who are licensed,* of whom 10,590 are resident in California, and 2278 living in other States. To this number must be added about 784 additional names, to include California licentiates admitted since the 1941 State Board Directory came off the press (by examination, 487; by reciprocity with other States, 257; and by reciprocity through National Board certification, 40). This would give California a total of 11,374 physicians who are California licentiates living in the State. Again, of some 2464 Doctors of Medicine in California who are under the age of 36, about 592 were in active service at the time of the recent A.M.A. meeting.

* * *

Executive Officer Seeley's Opinion of California's Quota.—Coming back, now, to Major Seeley's letter, in Paragraphs 2 and 3 it is stated that fewer than 1000 California Doctors of Medicine are in active service with the Armed Forces; and that California's total quota of physicians to be supplied—in relation to the total number of licentiates as compared with other States—will require the added induction of 2600 Doctors of Medicine. In other words, a total of about 1800 physicians must be taken from private practice for induction as members of the Medical Corps, between the present date and December 31st of this calendar year.

* * *

Situation as Regards Physicians under the Age of 45.—The real significance of what is involved in the figures just given, however, is sharply outlined in Major Seeley's letter when he states:

(5) I would emphasize that the majority of physicians of military age, i.e., those under 45 must anticipate military service sooner or later, except in the proven instances where they cannot be spared from civil life.

If this declaration had come from a less authoritative source than that of the Executive Officer of the Federal Procurement and Assignment Service, doubt in regard to the needs discussed could easily arise. Received, however, in answer to specific questions, and from the source

bureau through which all procurement directives and other information are sent forth, there can be little question concerning the thoughts expressed.

* * *

California not the Only State with Deficient Record.—Furthermore, in a succeeding number of the *Journal of the American Medical Association* (issue of June 27, 1942, page 715), a supplementary statement from Mr. McNutt is given, from which the following paragraphs may be quoted:

... In fairness to the recruitment record of many of our states; it seems in order at this time to give the profession some further idea of how its problem is distributed. The failure of a sufficient number of physicians to volunteer for military service is not spread thinly over the whole country. There is an acute lag in certain populous states. Other states have supplied nearly all that they should supply.

We need more than twenty thousand additional physicians by the end of this year. But eight states—New York, Illinois, California, Pennsylvania, Massachusetts, New Jersey, Michigan and Ohio—should account for nearly sixteen thousand of that shortage. . . .

The seriousness of the deficit in the number of physicians available for armed forces should not be underestimated. The need must be met. It will be met by one method or another. Neither must we underestimate the serious drain this puts on available medical services in civilian communities. It will mean long hours and hard work—sacrifices which will multiply the deep debt that every community owes to its physicians. . . .

It is my belief that the lag in recruitment has been due chiefly to the fact that the individual physician has not realized the genuine urgency of the need. Measures must be taken which will bring those needs home to every individual. This means that there will have to be some education of the general public. Preventable illness must be reduced to a minimum. Unreasonable demands on the physician's time must be reduced to a minimum. Thus only may available medical service adequately cover the needs.

* * *

Concerning Dependency and Occupational Deferments.—Equally significant are Paragraphs 6 and 8 of Major Seeley's letter referring to occupational and temporary deferments for physicians of 35 years of age and under. The statements contained therein certainly are worthy of the most serious consideration by all Doctors of Medicine to whom they apply.

(6) In the majority of the instances, the deferment of a man under 45 can only be considered temporary, and wherever necessary a replacement should be obtained from among those over 45, the women physicians, or those under 45 who have been rejected for military service.

(8) Since the question of dependency has practically been eliminated under Selective Service opinions, the remaining cause for deferment is occupational. In those cases where this office considers a man to be available, we feel justified in challenging deferment on an occupational basis. We do not want to have to resort to such a challenge.

* See page 30 of March, 1941, Directory of the Board of Medical Examiners of the State of California.

Request Concerning Needs within Next Two to Six Months.—We feel free to state, under existing conditions, that we do not understand how it will be possible to transfer 900 California Doctors of Medicine from civilian to military status within the next 60 days, i.e., before August 20, 1942.

That, however, does not make the urgency of the need one whit less than actually exists, and it may be assumed that the California Procurement and Assignment Service, acting through the California Chairman, Dr. Harold A. Fletcher of San Francisco (in charge of procurement for the Northern portion of California), and his Associate Chairman, Dr. Edward M. Pallette, of Los Angeles (charged with the responsibility of supervision and coördination of efforts of component county groups in the Southern section of the State), will do all within their power to promote the objectives of the Federal Procurement and Assignment Service.

Certainly, it must be agreed by all members of the Medical Profession that prompt surveys and alignments are now in order, if our Country's Manpower Commission, appointed by President Roosevelt, is to be supplied with the medical personnel so urgently needed for the tasks immediately ahead.

PROPOSED BASIC SCIENCE INITIATIVE FOR CALIFORNIA

California Has Needed a Basic Science Law for Many Years.—For many years, since 1927 in fact, and in these editorial pages, the need of a Basic Science Law, through which the health of the citizens of California would be protected from the services of licensed healing-art practitioners, who do not possess adequate preliminary and other education, and who through improper licensure, otherwise might be called upon to administer to the needs of sick and injured citizens of the State, has been repeatedly commented on.*

Since 1927, as stated, a program of education has been consistently carried on by the California Medical Association, during which period two separate Assembly bills were presented at Sacramento; as try-outs, to learn the reaction on legislative measures through which there might be brought into being in our State, a qualifying certificate board by name, "Basic Science Board," from which would be required a certificate on primary or fundamental education from every applicant for a healing-art certificate, before he or she could be eligible to take an examination by any one of several healing-art boards now existing in California. Therefore, it should be of special interest to all Doctors of Medicine in California to learn that the proposed Basic Science Initiative, sponsored by the California Medical Association, the California State Dental Association, the Southern California State Dental Association,

and the Public Health League of California, will actually find a place upon the November, 1942, ballot as one of several initiatives and measures then to be favorably or unfavorably voted upon. Note:—On the ballot, the Basic Science Initiative will have Number 3. Do not forget the number (3).

* * *

Basic Science Initiative will be on November Ballot: Then What?—This last statement concerning possible non-approval by the voters of California is made with a triple purpose:

(1) To permit the members of the California Medical Association to know that their Basic Science Initiative will be on the November, 1942, ballot;

(2) To inform them that the invidious and confusing "Basic Subjects Act"*, sponsored by certain Chiropractic groups, will not be on the ballot—not a single county in California having presented Chiropractic petitions to the Secretary of State. (Whether these are being held back for some future years, is not known at this time);

(3) To acquaint members of the California Medical Association concerning the heavy work and tasks yet to be done.

It may be well for non-sectarian practitioners of the healing-art, i.e., those of us who call ourselves regular Doctors of Medicine, to reflect for a few minutes on certain principles to which our own group of non-sectarians have always given allegiance.

* * *

Some of Our Tenets.—For, speaking of ourselves, we may state:

(a) We approach the practice of healing-art with open minds, and without preconceived notions or dogmas concerning the causation or course of diseases or injuries; and according to our teachings, we are permitted to use anything and everything that may make for the prevention or cure of disease or injury, so long as its administration does not promote personal or group profit or aggrandizement to the detriment of the public health.

(b) We decry and oppose, as unscientific and irrational, the postulates of all healing-art practitioners, no matter to whose group or cult they belong, who espouse or promote, before the public, those healing-art methods that are a contradiction to common sense or other logic.

(c) We believe, and hope that our lay fellows also hold, that every healing-art practitioner, no matter to what group he or she may belong, who himself stands before the public as a healing-art practitioner, and licensed by the State as such, shall and must possess at least a minimum preliminary education, to indicate that when he pursues his professional training, he shall have at his disposal a background of basic or primary knowledge, that will permit State Licensing

* For those who wish references, see CALIFORNIA AND WESTERN MEDICINE, issue of August, 1941, on page 104.

* For photostatic copies of misleading allurements, see CALIFORNIA AND WESTERN MEDICINE, April, 1942, on pages 228-229.

Boards in the Healing-Arts certain assurance, that no matter what be his views concerning treatment measures, he shall still have had sufficient fundamental or preliminary education to demonstrate an adequate knowledge of the nature, course and treatment of human diseases and injuries.

In other words, bluntly put, and in reverse, the great State of California, has no right to place in the care of *incompetent* practitioners of the healing-art, the health and lives of its citizens. If life is sacred, as our many criminal laws suggest, why should it not be safeguarded, likewise, from incompetent practitioners? It is quite true, that legislatures not infrequently, in response to specious pleas, do enact improper licensure regulations—these in spite of the protests of scientific medicine;—but such action is largely a reflection on all who are guilty of such acts, and must not be cast in reproach upon those who protested the submitted legislation.

In making these statements, there is no vindictiveness. Not to portray these fundamental facts, would be a betrayal of patent and inviolate precepts.

* * *

Tentative Conclusions.—To what, now, do the foregoing and similar thoughts lead us, in so far as the proposed Basic Science Initiative is concerned:

The answer is: To nothing more than this, namely, that:

(a) A Basic Science Initiative will be placed on the California Ballot non-retroactive for all practitioners of the healing-art now licensed, but applicable to applicants of the days to come; and

(b) The real struggle for the enactment into law in November, 1942, of this proposed initiative is now in the lap of the Medical Profession of California, and of the friends of that profession.

We, ourselves, placed it there. There it will remain, for better or for worse. If, at this time we each, and all of us, fail to do our respective parts, the end-result may be nothing else than the non-enactment of the initiative by the electorate, implying by that, not only disaster for the present, but also, for many years in the future.

True, these may be unpleasant thoughts. Better said, however, in advance, than afterward. It is important that every Doctor of Medicine in California, should fully appreciate his personal responsibility in the issues at stake.

* * *

Recapitulation.—To place the proposition bluntly, let us recapitulate:

(1) Since the year 1927, a Basic Science Law has been consistently advocated in California.

(2) Two trial ballots were submitted in the California Legislature, in an effort to learn the sources of possible opposition.

(3) The initiative law is the only method that would make such a measure applicable to existing

healing-art groups already recognized by the State of California (so-called Regulars, Osteopaths, and Chiropractors.)

(4) The Basic Science Law sponsored by the California Medical Association, the State Dental Associations, and the Public Health League will be on the November, 1942, ballot.

(5) In spite of their high pressure methods, the effort to have a "Basic Subjects Law," as proposed by certain Chiropractic groups, died "a'bornin'."

* * *

Real Battle for a Basic Science Law is Still Ahead.—But, in spite of all the above:

The Real Battle is now about to start.

Let there be no doubt about that.

Keep in mind, those of you who were in the superoptimistic group at previous C.M.A. annual sessions, and told how easy it would be to secure 200,000 or more of valid names of voters, that after a very strenuous campaign, with many legal workers, a total of only 107,000 valid signatures were secured from doctors, dentists and their friends.* The other signatures, between that number and up and beyond the 212,117 needed, were obtained through commercial solicitors, for cash, and on which the regulation fee of ten cents plus was paid. The money so expended ran into some thousands of dollars. This is stated simply to emphasize how, on matters concerned with public health, i.e., on non-personal interests, we are willing so often to let the other fellow do the work; and, sad to relate, if failure results, we who have been derelict ourselves, are prone to cast reflections, not on ourselves, but more often on the "Other Fellow," or, easier still, on the "Officers of the Association," who supposedly did not do their part. Such is human nature!

In placing the matter so frankly, and in form, perhaps, almost to arouse antagonism, our sole motive is to attract sufficient attention to make members of the California Medical Profession—and through them, their friends and supporters—realize that the Real Fight for the enactment of this Basic Science Initiative is still ahead of us.

* * *

Chances of Initiatives in a State Election.—

A brochure, "The Initiative and Referendum in California," from the John R. Haynes Foundation of Los Angeles (it was the late John R. Haynes, M.D., of Los Angeles who was the sponsor of the California Initiative), states:

... From the adoption of Direct Legislation in California in 1912 until 1938, ninety-nine initiative propositions have been submitted to the electorate, of which forty-one were statutes. ... Of the initiatives voted on, twelve statutes have been approved by the electorate. ...

The above statement is worthy of thought because it indicates that it is more than four to one that a "statute initiative" (and that is the class to which the Basic Science Initiative belongs) will be voted down!

* Of the 107,000 signatures so secured, 70,000 were valid.

Now these were all patent facts before we engaged upon this struggle to protect the citizens from incompetent healing-art practitioners. What do these facts imply?

* * *

The Task Ahead: What Shall the Story be? Victory or Defeat? And Upon Whom Must the Responsibility Rest?—Is it not plainly evident, from what has been here presented, that the Basic Science Initiative, promoted and intended for the protection of the citizens of California, will be enacted only if the voters of California appreciate its beneficent purposes?

At the present time, the struggle is even more difficult, because with War psychology everywhere in evidence, it may be said there is only transient or casual interest in State and local politics. Meaning what? That, by-and-large, the voters will go into the booths in November next, and vote No rather than Yes, on initiatives, referendum and similar measures. These are the cold facts, based on the recorded analyses of initiative measures submitted since the year 1912. To ignore them, lays the groundwork for defeat. And then, what?

* * *

The Objective is Laudible. But Doctors of Medicine and Their Clients and Friends Have a Hard Fight Ahead.—The battle can be won and it will be won for the betterment of California's citizens, if every Doctor of Medicine will do his part and lend his fullest aid, through himself and his friends, to carry on, between now and November election day, a strenuous campaign of education of all voting citizens.

This means, the educational campaign must be carried on in good part by physicians; through direct conversations with their patients and friends, and contacts with service clubs, and other groups with which they have affiliations. It envisages coöperation by members of the State Woman's Auxiliary and its component county groups, by Doctors of Dentistry, Pharmacists, and other learned professions.

* * *

The Story to be Told.—The story to be told is so simple, so honest, and so fundamental, that, in essence, it is as follows:

The State of California should license only those practitioners of the healing-art—no matter to what school belonging—who have given evidence through examination, that they possess sufficient fundamental education to indicate that health and lives of citizens may be safely placed in their care, and that they are, therefore, worthy as applicants for State Licensure.

And primarily, that is all a Basic Science Law is intended to promote. Surely, every citizen has an interest in that kind of protection for himself and for those whom he loves.

If we can get this basic message across, success

will be ours. If we, as physicians, fail to educate our fellows concerning their own primary interests, and our own kindly desire to aid in their protection, we may go down to defeat. This in spite of all past effort and funds expended in sincere desire to place this law on the statute books of California.

Doctor, you who read this, will you do your part?

ANNUAL SESSION OF AMERICAN MEDICAL ASSOCIATION: A.M.A. TO MEET IN SAN FRANCISCO IN 1943

Some High-Lights of Recent A.M.A. Session.—The recent annual session of the American Medical Association, held in Atlantic City on June 8-12, was characterized by interest and enthusiasm, so much in evidence at this year's convention of the California Medical Association held at Del Monte, on May 3-6, last. Registrations of A.M.A. members in eighteen scientific sections totaled 8328, some 180 physicians from California being in attendance.

The Section meetings were interesting, but special mention must be made of the Scientific Exhibits which, more and more, are taking on a dominating place at the annual meetings of the National Association. The great interest of physicians in the newer researches and work, as given in these exhibits, was evidenced by the unending and attentive groups which crowded practically all the booths. Certainly, this type of post-graduate work is having much appeal to that increasing number of physicians who wish to contact and exchange views with colleagues whose work is not only thought-stimulating, but valuable in practice.

In this connection, the hope is expressed that members of the California profession will lend fuller coöperation in building up the scientific exhibits of our own State Association. Praise should be given, also, to the medical and surgical films which were presented in Atlantic City. The rooms allocated for these were constantly crowded.

* * *

San Francisco, as Meeting Place, Was Decided in 1940.—New York was selected as the place for A.M.A. session, to be held in 1945, three years hence; just, as in 1940, the A.M.A. House of Delegates decided that San Francisco should be the place of meeting for 1943, next year's session.

For a brief period, by the underground, it was rumored about that hotel and commercial interests of one or two mid-west cities intended to stampede this year's House of Delegates into changing the place of meeting from San Francisco. The California delegates promptly let the word go out that such an action was not within the power of this year's House; and the movement, while not absolutely quashed, found no spokesman who dared give expression to the plan

at any of the House meetings. In case of a War emergency, necessitating a change in meeting place, the authority for such action is vested, by the A.M.A. constitution, in the Board of Trustees.

* * *

San Francisco a Logical Place for an A.M.A. Session.—What War will bring forth, is difficult to forecast; but surely, there is no need to incite a fear-morale that would make physicians reluctant to visit the West Coast. The citizens of San Francisco, Los Angeles, Portland, Seattle, and other coast communities are proceeding with their daily routine and living, even though, perhaps, they may be somewhat more alert to the Country's military needs, than are those who are resident in some other regions.

San Francisco is one of the few cities in the United States capable of providing an annual session of the American Medical Association with every desired comfort and convenience. It has ample hotel accommodations, all centrally placed in the heart of the city, and in close proximity to the Civic Auditorium, with its spacious halls for section meetings, exhibits and films. Taxi service is excellent. The Twin Peaks and other hills cut off the heart of the city from direct contact to the Pacific Ocean, so that dim-outs are practically in less evidence than in most of the cities facing the Atlantic Ocean. So short a time ago as February last, San Francisco was host to the successful convention of American School Superintendents, at which a registration of 12,174 was recorded.

It is agreed that good reasons may be put forward regarding the undesirability of joy and pleasure conventions of what are primarily social organizations, but those arguments do not apply to scientific groups such as the American and California Medical Associations, whose members, in these present days more than ever, need to acquaint themselves with new methods and responsibilities, particularly in the realm of War Medicine. There is nothing to indicate that military authorities have any desire to interfere with legitimate gatherings.

Concerning the February meeting of the American School Superintendents, extra-state commercial interests started antagonistic rumors, in the hope of causing a transfer of meeting place. The fact that more than 12,000 teachers registered for that meeting—conceded by those in attendance as one of its best on record—shows the fallaciousness of such propaganda. In similar manner, prior to the recent C.M.A. meeting at Del Monte, stories kept going out up to the end of April, that there would be "No C.M.A. session in May of this year." The attendance of 1724 persons at that meeting, and the almost universal verdict that it has been one of our best conventions, is further testimony on why a most successful meeting of the A.M.A. can be held in San Francisco.

* * *

Cordial Welcome is Extended.—Next year's session of the American Medical Association in

San Francisco will be enthusiastically supported by the local hosts, the San Francisco County Medical Society and the California Medical Association, and every effort will be made to promote a convention, that both intra- and out-of-state members will long remember; both for the value of its scientific work and the joy of foregathering in San Francisco, which is one of the half dozen American municipalities with historical background and picturesque surroundings, permitting it to stand in a class of its own. These thoughts are presented, therefore, to invite colleagues, in other States of the Union, to arrange their plans to join with Californians in making the 1943 session of the American Medical Association one of the best on record.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 60.

EDITORIAL COMMENT†

GOOD PRACTICE VS. MALPRACTICE

The incidence of malpractice claims is higher in California than elsewhere in the United States. Particularly is this true of the metropolitan centers, where the condition is both vicious and alarming. Because of the many claims and suits, physicians are suffering loss of prestige and great loss of time; moreover, they are being subjected to an increasingly heavy financial burden. Something must be done to meet this problem.

Theoretically, a doctor should be able to avoid accusations of malpractice if he cares for every patient with meticulous attention to the requirements of good medical practice. Actually, as the most unprejudiced analysis will disclose, the great majority of malpractice claims made, and suits brought, are without meritorious foundation. It is essential, therefore, that for his own protection the physician should endeavor, in so far as possible, to be in a position to prove that he has cared for every patient with the requisite degree of skill and care, in accordance with the standard imposed by the law.

Good medical practice is in itself not enough: the physician must be able to show proof of what he has done. California physicians must come to realize the seriousness of the malpractice problem and must determine to ameliorate the situation.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

When and if this awareness and determination can be achieved, the present ratio of ten or more cases in certain California counties to one case in counties of comparable population in some other sections of the country will change very markedly.

At the present time it may be wise to note that a physician who enters the military service, and leaves his civilian practice to be carried on by partners or by employees, is liable for their negligence or malpractice just as though he were still at home. In this connection the following case is illuminating and augurial: A partnership was held to exist in *Runo vs. Rothschild* (Michigan),¹ wherein a physician, while in the service of the United States Army, agreed to permit his assistant to continue the occupation of his offices and laboratory, and to practice for the plaintiff's patients, the income derived from such practice to be used to pay all expenses, and the balance to be shared equally.

It should also be remembered that the physician's liability as regards malpractice is not changed when he is treating military personnel as a medical officer of the armed forces. The Judge Advocate General of the Army has held that members of the Army are entitled to the same civil rights of action between one another with reference to suits for malpractice or negligence as they would have in civil life.²

6777 Hollywood Boulevard.

LOUIS J. REGAN,
Los Angeles.

REFERENCES

1. 189, N.W., 183.
2. J.A.G., 707 (March 6), 1934. J.A.M.A., Vol. 117, No. 11, P. 936 (Sept. 13), 1941.

POTENTIAL DANGERS OF KEROSENE, GASOLINE, AND SIMILAR SOLVENTS FOR HANDLING BLISTER GASES ON THE SKIN

The common blister gases, such as mustard gas and lewisite, are soluble in kerosene, gasoline, acetone, carbon tetrachloride, and other similar fat solvents. During World War I, it was naturally assumed that such solvents would be useful in removing splashes of liquid blister gases from the skin. No data have appeared to support this idea. Nevertheless, the recommendation for the use of these fat solvents persisted, and has been taken over in current advice to civilians with respect to removing liquid splashes of blister gases from the skin.

It should be remembered that kerosene, gasoline, and acetone may be absorbed by the skin, and like carbon tetrachloride, are themselves skin irritants. They are also solvents of low viscosity and tend to spread easily. There is thus every likelihood that the use of these solvents would not satisfactorily remove a blister gas from the skin, but would on the contrary spread it over the skin, and produce a more serious injury than if they were not used.

Direct experimentation supports this view. In the chemistry laboratories of the University of California, Professor T. D. Stewart has studied mustard gas burns on the skins of many score of students. In our laboratory we have made similar studies on animals and human skins. Uniformly we have found that simple detergent solutions such as those produced by soap and water are more effective if used promptly in removing blister gases from the skin than are such solvents as kerosene, gasoline, acetone or carbon tetrachloride. The latter frequently produced more extensive and severe burns in connection with blister gases on the skin than are noted in untreated controls.

It would seem wise, therefore, to revise recommendations to civilians for handling potential gas injuries by removing all reference to such solvents as kerosene and gasoline. Revisions have already been made in national recommendations with respect to the use of hydrogen peroxide for treating gas injury to the eyes, particularly if lewisite is suspected. The original recommendations were to wash the eyes with a 3 per cent solution of hydrogen peroxide. Direct experimentation by Professors P. J. Hanzlik and M. E. Tainter at Stanford Medical School and by ourselves showed the potential danger to the eye of such a relatively strong oxidizing solution. This was confirmed by Chemical Warfare Service workers, and the recommendation was revised to a 0.5 per cent solution. Later, this was abandoned entirely, and the suggestion of the San Francisco Committee on the Medical Aspects of War Gases was adopted, namely, to wash the eyes with a 2 per cent solution of sodium bicarbonate.

The simplest and most effective advice for civilian protection against war gases seems to be: (1) obey air-raid rules, taking refuge in an air-raid shelter or blackout room with doors and windows shut; (2) if the shelter is broken open by bombing, and war gases are suspected by odor, fog, or smarting or stinging in eyes, nose, throat, or by sneezing or coughing, tie a cloth soaked in soda solution over the nose and mouth to breathe through, shut one eye, squint through the other, and lie down with head in arms; (3) if eyes, nose, or throat are irritated, wash out with solution of teaspoon of baking soda in glass of water; (4) if it is suspected that splashes of liquid are on clothes or skin, throw clothes out of window, lather skin copiously with soap and wash thoroughly, or blot the contaminated skin with a cloth wet with a 3 to 5 per cent buffered kitchen bleach solution of sodium hypochlorite, such as "Clorox," "Sani-Clor," or "Purex," and then follow with soap and water. If subsequent injury results, first-aid and medical management is symptomatic.

Pharmacology Laboratory,
University of California Medical Center.

DAVID F. MARSH,
CHAUNCEY D. LEAKE,
San Francisco.

ORIGINAL ARTICLES

Scientific and General

BURN WOUNDS: THEIR TREATMENT*

DON D. WEAVER, M. D.

Oakland

THE war, which has broken loose over most of the world, carries a high percentage of burn casualties, striking the civilian population as well as the armed forces. Many of us will be called upon to treat these wounds, and it is essential that we have a clear conception of the basic principles on which the treatment of burns is founded. Burns have become a major medical problem.

THE BURN WOUND AS A CONTAMINATED WOUND

Before taking up in detail the treatment we are using at present, I would like, briefly, to review the contributions made to this subject during the past fifteen years, which have given us our conception of the burn wound. This work was first stimulated by Davidson¹ in 1925, when he introduced the closed treatment of the burn wound by the use of tannic acid. After a superficial cleansing and debridement, tannic acid solution was applied to the burned surfaces, for twelve to twenty-four hours, until they were tanned to a mahogany brown or black. The patient was then kept dry under a warm cradle.

This method of treatment taught us two important facts. From the successful cases having uneventful recoveries, we learned of the many advantages of the closed, or dry method of treatment. The lack of pain, fever, dehydration, and emaciation were a welcomed contrast to the picture of burns we had known heretofore.

From the large percentage of cases in which infection developed, we learned that, except for the period of initial shock, infection was practically the only difference between success or failure.

A few years later, Vilray Blair² expressed the opinion that burns were all infected wounds after the first twenty-four hours, and should not be closed. He recommended the use of hypertonic immersion baths and compresses. We found his method technically difficult. Its disadvantages made it impractical for adoption as a standard method of treatment.

Aldrich,³ in 1931, after having taken cultures from burn wounds and finding them 100 per cent positive after the first twelve hours, endeavored to find an antiseptic that would prevent infection, and at the same time seal the wound. In 1933, he published his results, and recommended gentian violet as possessing these qualities.

In 1933, at the Alameda County hospital,⁴ because of the frequency of infection with both

tannic acid and gentian violet, and after having obtained positive cultures from 90 per cent of burn wounds immediately upon entry to the emergency ward, we began the aseptic preparation of the burn wound before any local application was made. All cases were taken to surgery. Under N₂O anesthesia, the burn wound was thoroughly cleansed with soap and water, followed by alcohol and ether. After cleansing tannic acid compresses were applied, and the patient returned to bed between sterile sheets under a warm cradle. Every effort was made to prevent wound contamination during the after-care.

Our results, which demonstrated a marked improvement over methods formerly used, were published in *CALIFORNIA AND WESTERN MEDICINE* in 1934.⁴ We stressed, in this article, apparently for the first time, the burn as a contaminated wound, and as such, should never be closed without preliminary cleansing. We emphasized the application of the principles of surgery to the burn wound in the same manner we would apply them to any other type of wound.

The use of silver nitrate in conjunction with tannic acid was introduced by Bettman⁵ in 1937. His claims, that infection was lessened and that coagulum formed more rapidly and was more pliable, have been substantiated. We have found silver nitrate useful with gentian violet, as well as with tannic acid, and have obtained equally good results from the so-called Triple Tan, when all three are used.^{6,7}

Triple Dye, a mixture of 2 per cent gentian violet, 1½ per cent brilliant green, and .1 per cent acriflavine, was suggested by Aldrich in 1937.⁸ It was the result of a long series of experiments in search of a bactericide which would possess the advantages of gentian violet and, in addition, destroy gram negative bacteria. Triple Dye has become very popular in the past few years, both in Great Britain and this country. Rear Admiral Wakeley, of the British Navy^{9,10} states that it is more widely used in England, during the present war, than any other burn application. Inasmuch as it is a closed treatment, the careful preliminary preparation of the wound is implied. This solution is stable for about one week, and, because it is sensitive to light, should be kept in an amber bottle.

Within the past two years, a method of treating burns has been recommended by the plastic surgeon utilizing the principles used in skin grafting.^{11,12} After a thorough aseptic cleansing, vaseline gauze, or fine mesh gauze, moistened in saline is applied. This is covered by voluminous fluffed gauze dressings held in place by a pressure bandage. The dressing is not disturbed for eight to fourteen days. This procedure is a closed treatment, depending for its success upon the meticulous preliminary cleansing. In a method for general use, we feel it is safer to choose one that permits the wound to be inspected daily for the earliest signs of infection.

One of the most spectacular contributions to

* Read before the Fourth General Meeting at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

medicine in the past few years has been the introduction of the sulfonamides. Robson and Wallace, in 1941,¹³ reported favorably on the use of sulfanilamide paste on war burns. The same year Pickrell¹⁴ reported one hundred cases treated successfully with 3 per cent sulfadiazine in 8 per cent triethanolamine. He recommended the immediate spraying of the burn with this solution, to relieve pain and limit bacterial growth. As soon as possible, thereafter, the wound is aseptically cleansed and debrided, after which it is sprayed at regular intervals for several days until a firm coating, or eschar, covers the wound. During the past year there have been numerous reports¹⁵ of the successful use of sulfanilamide and sulfadiazine, but the high-blood level, which at times follows their local use in small burns, indicates there is danger of over-dosage, if applied indiscriminately.¹⁶ Pickrell reports only one case as showing toxic effects of absorption. Their use should be encouraged in hospitals where their action, advantages, and disadvantages can be carefully recorded. It is quite likely that a sulfonamide compound will eventually prove a valuable contribution to burn therapy.

In 1941, Bunyan, of Oxford, described a waterproof envelope which he devised especially for treatment of burns of the extremities, wherein the burn area is constantly irrigated with electrolytic Hypochlorite solution. We are not familiar with this type of treatment and cannot comment upon its merits.

Paraffin wax, which was popular as a burn treatment during the last war, later lost favor because of the frequency of infection. It has been again recommended for use in some of our naval hospitals. Our experience with paraffin wax on fresh burns has been highly unsatisfactory.

In the *New England Journal of Medicine*, of April 16, this year, Wells presents evidence, gained at autopsy and animal experimentation, that severe liver damage may be caused by the absorption of tannic acid. He states that the injury to the liver varies from a mild hepatitis to central necrosis, depending directly upon the amount absorbed.¹⁷

It may be confusing, when we review the current literature on burns, to find capable surgeons, each recommending a different type of burn application and obtaining successful results. The treatments most in favor include triple dye, tannic acid and silver nitrate, gentian violet—with or without silver nitrate—gentian violet jelly, sulfanilamide, sulfadiazine, and pressure dressings applied over vaseline gauze or fine mesh gauze moistened in saline. From these apparently divergent views we find the key to the successful treatment of the burn wound. *The successful results are due to the careful preparation of the wound, and the alert, painstaking after-care, rather than the specific type of application.*

SHOCK

In the general management of the burn case, as in other forms of severe trauma, shock warrants our first consideration. The many contributions made to this subject, during recent years, have led to a marked improvement in treatment and to a reduction in mortality. Clinical and experimental evidence show that severe shock causes an increased permeability of the capillary walls, with a leakage of the fluid elements of the blood into the tissues. These consist primarily of plasma proteins and, in turn, water and salt. The results are a fluid imbalance, a concentration of blood in the vessels, lowered blood volume, a slowing up of the circulation, with a consequent anoxia of the tissues and organs of the body.¹⁸ With a consciousness of the importance of fluids and fluid balance, a few simple tests are necessary to determine the requirements of the patient suffering from shock.¹⁹ The determination of the plasma protein of the circulating blood, together with the clinical picture will, in most cases, suffice. Scudder states that the information most important is the trend toward, or away from normal, as judged by repeated tests rather than by a single set of determinations. There is now general agreement that plasma or serum transfusions, supported by an adequate amount of saline, are the best type of replacement therapy.

In mild cases, from 250 to 500 c.c. of plasma is usually sufficient. More severe cases may require from 500 to 1000 c.c., depending upon the clinical picture and plasma protein determination. In very extensive burns, as much as ten liters may be required over a period of days.

When the plasma proteins are low, glucose and saline solutions by themselves fail to aid the situation, and actually tend further to wash plasma proteins out of the circulation.²⁰ The latter are required to raise and maintain osmotic pressure which, in turn, keeps the water and salt in the vessels. From 3500 to 4000 c.c. of fluid intake is usually all that is required by the average patient to balance the insensible loss of water and urine. Moderate amounts of glucose and saline, in addition to plasma, may be necessary to balance this fluid loss, but the administration of large quantities of this solution alone, defeats the purpose for which it is given.

Some evidence has been presented to show that adrenal cortical hormone, when given in conjunction with plasma decreases the leakage of plasma proteins, thus lessening the amount of plasma it is necessary to transfuse.

The relief of pain with morphia, the maintenance of body heat, and the administration of oxygen are general measures to be used, according to the requirements of the patient.

FRESH BURNS

In fresh burns involving the larger body surfaces we prefer a closed or dry method of treatment. Intravenous therapy and general care are more easily administered, with a restful patient

free from pain and the necessity of painful dressings. At the present time, we are using triple dye for this purpose. Aside from its bacterioidal action, it is inexpensive and easily applied. These factors are important in an emergency where time and equipment must be considered.

As soon after admission to the hospital as the condition of the patient will permit, the burn wound is quickly and thoroughly cleansed and debrided, using white bar soap, large cotton swabs, and an abundance of warm water. A solvent is used to remove grease. This operation if done quickly and gently, can usually be done under morphine analgesia. If deeper anesthesia is required, cyclo propane is used. When the wound is thoroughly cleansed, several coats of triple dye are applied with a spray, each coat being dried with a warm air dryer. The patient is then returned to bed between sterile sheets, under a warm cradle. In the after-care, every effort is made to prevent wound contamination.

INFECTED BURNS

When six or more hours have elapsed before a burn is treated, it should be considered as an infected wound. These burns, like the grossly infected, should not be closed with coagulants. The wounds are first gently cleansed and debrided. After cleansing, our treatment varies with the individual requirements of the case. The sulfonamide drugs, saline compresses, immersion baths, and dry warmth may be used as the occasion demands. Baths and compresses are usually alternated with periods of dry warmth, to prevent maceration of the tissues. Hexylresorcinol in mucilage Tragacanth has proved useful in some cases.

When triple dye is used to combat infection or to add to the patient's comfort, only a thin coating is applied, which can be easily removed in the bath or by moist compresses. When crusts tend to form, overlying pockets of infection, we use the saline immersion bath for one hour each day. There is no specific treatment for this type of burn.

REGIONAL BURNS

Burns of the hands, feet, face, and genito rectal regions deserve especial consideration. It is difficult to secure and maintain asepsis in these areas. Infection frequently occurs, carrying with it the risk of serious disability and disfigurement. We have not attempted any form of closed or dry treatment upon these areas for the past seven years.

Burns of the hands are frequent among war casualties, and one of the common causes of disability and invalidism from the service. These wounds are rendered aseptically clean, and every effort is made to keep them clean. Except for the meticulous cleansing and debridement, the treatment we are employing is similar to the treatment for infected burns.

Our usual routine consists in moist saline com-

presses applied for about twelve hours daily. This is most conveniently done at night. Every morning the dressings are gently floated off in a one-hour saline bath, in which flexion and extension of the fingers are encouraged. This is followed by dry warmth under a cradle until the compresses are reapplied. Hand burns grossly infected upon admission are dusted with sulfanilamide before applying compresses. As soon as the surfaces are healed, the delicate reddened skin is gently massaged several times each day with lanolin. Active and passive movements of the fingers are continued. Without this care, disability may be prolonged for several months.

Burns of the face are time-consuming and difficult. Infection usually occurs. After these wounds have been cleansed and debrided, they are dusted with sulfanilamide, and compresses are applied. In face burns, grossly infected, an 8 per cent solution of sulfanilamide is applied as a compress for several hours daily.

Crusts overlying pockets of infection, that tend to form about the face, head, and neck, may be softened with peroxide and removed by gentle cleansing with warm water and soap. Vaseline gauze or cod liver oil ointment is applied over bleeding points to prevent dressings from adhering. To add to the patient's comfort, these wounds are occasionally painted with a thin coat of triple dye, and left exposed during the day.

Burns of the feet and the genito rectal regions are treated as infected burns, with the alternate use of dry warmth and saline compresses. A thin application of triple dye may also be used. Immersion baths are used when the wounds are soiled and crusted.

We wish to emphasize the importance of early skin-grafting in all areas where the skin is destroyed. Early grafts relieve pain, minimize the fluid loss, shorten convalescence, and prevent scar tissue contractures and disabling deformities.

FIRST AID

In the first aid treatment of the burn wound a simple covering of sterile gauze is sufficient. The use of ointments, oils, and tannic acid preparations only add to wound contamination, to the problem of cleansing, and to subsequent danger of infection. A sulfonamide may be used when early cleansing is not feasible.

CONCLUSION

It is quite possible, with the renewal of interest in this subject, that the local treatment of the burn wound will undergo many changes before this paper is published.

Of the sulfonamides, only the first chapter has been written. With the large amount of experimental work in progress, it is more than likely that a sulfonamide compound not yet released may play an important part in the treatment of the burn wound, and supplant the local applications now in favor.

In our enthusiasm over new contributions as

they appear, we should not lose sight of the fact that the burn is a contaminated wound and its treatment a surgical problem. This implies a careful preliminary preparation of the wound and an equally important painstaking after-care.

The successful care of the patient who has suffered from severe burns is not easy. It takes time and hard work, but the author knows of no instance where your efforts will be as generously rewarded.

400 29th Street.

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THE PHYSICIAN AND THE NATIONAL NUTRITION PROGRAM*

DWIGHT L. WILBUR, M.D.
San Francisco

DISCOVERIES of and about vitamins initiated a great development in the science of nutrition, and the occurrence of the war is precipitating profound changes for the people in the practical application of this scientific information. It is the purpose of this presentation to discuss the latter phase of this matter, and to consider the place of the physician in the National

Nutrition Program.

By way of introduction, one may well ask the question—whether there exists a national nutrition problem? Are all of the people in our country adequately nourished in terms of modern knowledge of nutrition? If not, how many are not well-nourished, in what ways do they fail to be adequately nourished, and what can be done to see to it that they become properly nourished? In the brief period allotted for this discussion it is not possible fully to answer these questions. To present evidence of the existence of a national nutrition problem, I should like to quote the conclusions of a subcommittee of distinguished nutritionists,¹ appointed by the Food and Nutrition Board of the National Research Council to evaluate existing evidence on the question of the prevalence of malnutrition in the United States. It is stated that: "The evidence at our disposal warrants the conclusion that dietary inadequacies and malnutrition of varying degrees are of frequent occurrence in the United States, and that the nutritional status of an appreciable part of the population can be distinctly improved. If the optimal nutrition is sought, not mere adequacy, then widespread improvement is possible."

THE NATIONAL NUTRITION PROGRAM

The immediate background, for the present National Nutrition Program, may be said to date from the spring of 1940. At that time a newly-appointed committee on Food and Nutrition of the National Research Council was requested by the Surgeons General of the Army and Navy, to give advice concerning the rations of men in the armed forces. It is no military secret that, until that time, the ration of Army and Navy personnel had been considered nutritionally in terms only of calorie and protein content. Now, with a large group of men coming into active duty under the Selective Service Act, it seemed wise to consider, in the feeding of them such things as vitamins and minerals, as well as calories and proteins, and the need for these various factors under a large variety of conditions. As a result of this activity, there was precipitated much interest in problems relating to the nutrition of all of the people. In turn, this led to initiation of the program for enriched flour and enriched bread, and calling of the National Nutrition Conference for Defense held in Washington in May, 1941, at the request of the President of the United States. There was also set up a Nutrition Advisory Committee to the Coördinator of Health, Welfare and Related Defense Activities (now the Office of Defense Health and Welfare Services), and subsequently a Division of Nutrition in the Office of Defense Health and Welfare Services, of which Mr. M. L. Wilson is the chairman.

The interest in nutrition stimulated by people in these groups was intense, and has led to a National Nutrition Program which is given scientific guidance by the Food and Nutrition Board

* Chairman, San Francisco County Nutrition Council. Read at the general session of the California Medical Association, Del Monte, California, May 3-6, 1942.

of the National Research Council. Professors of home economics in the land-grant colleges in each state were designated as chairmen of state nutrition committees, and encouragement was given to the development of nutrition committees in each county in the United States, with representation thereon of physicians, dentists, nurses, home economists, dietitians, and public health officials, and laymen of action groups, such as the Parent-Teachers' Association, Red Cross and American Legion, of food manufacturers, retailers and distributors, and of numerous other agencies. In essence, the function of the county nutrition committees is (1) to coördinate and assist in nutrition programs of the state and county, as developed by permanent agencies in the community, and (2) to initiate and carry out projects for the attainment of better nutrition in the community. In other words, this phase of the campaign is largely an educational one, to see to it that every child and adult shall have information on the essentials of good nutrition in terms of foods which are available to them.

The causes of malnutrition are (1) economic difficulties in obtaining proper food, (2) lack of information as to what constitutes an adequate diet, and (3) the widespread availability and use of processed foods from which vitamins often have been partially removed or destroyed in manufacturing or processing. It has been stated that there are three ways in which the problem of malnutrition may be met on a large scale: (1) by educating people regarding an optimal diet, (2) by giving to each of us daily a vitamin pill or tablet, or (3) by restoring to foods vitamins and minerals removed from them in the process of manufacture or preparation—namely, by the so-called “enriching” of foods. Of these the first and the last are the only practicable and sound solutions economically and nutritionally. The matter of enrichment of foods is one to be taken up on a national scale, and is not the function of a state or county nutrition committee alone. However, local groups have, as their principal task, the matter of educating people as to what to eat to be well-nourished and healthy. This task may be accomplished in part by existing agencies whose activities are coördinated with those of county nutrition committees. These activities center in courses in nutrition, nutrition demonstrations, further extension and development of the school-lunch program, studies of food habits of different races and types of people, encouragement of proper advertising of foods, education of children in good nutrition, determination of methods to assist those in low income groups to be adequately nourished, stimulating the development of and maintaining a library of books, posters, pamphlets, movies and other informative material on nutrition for public use, and in numerous other fields.

THE RÔLE OF THE PHYSICIAN

What is to be the rôle of the physician in developing and furthering this National Nutrition

Campaign? Is he to sit idly by, while others not trained in medicine but well versed in the science of nutrition and in methods of educating and selling, assume leadership in a campaign which deals so closely with the health of his patients and people in general? Can he nonchalantly ignore the ever-growing number of dietary quacks who now find in the national campaign a helpful stimulus to sell more and more of this or that favorite vitamin pill, syrup or “health food”? Indeed not! It is he who must provide a positive leadership in this national and local effort, to raise the standards of nutrition and, consequently, the health of the people of the United States.

How is it to be done? The answer is simple. As pointed out by Sebrell,² it depends on the development of a new point of view in preventive medicine—a point of view which already recognizes the importance of such things as vaccination against smallpox, immunization against diphtheria and sanitation of water and sewage, but still more is concerned with building the healthiest possible population with the greatest resistance to disease. A major part of such a program is that the population shall receive a diet adequate in all respects. In other words, the physician must begin to think more and more in terms of health than of disease, particularly as it applies to nutrition. Potentially, nutrition offers more to medicine—preventive and therapeutic alike—than has been offered by any branch of medicine, not excluding bacteriology, chemistry, surgery and chemotherapy, and offers it in a very simple and certainly pleasant way. (In this connection it is worthy of note that dietary deficiency diseases are an unusual group of diseases, in that they are almost completely preventable and, with the exception of a few extreme examples, almost completely amenable to cure.)

HOW PHYSICIANS MAY GIVE LEADERSHIP

May I make the following suggestions of ways in which physicians may give leadership in this campaign:

(1) *Be familiar with the nutrition standards set up by the Food and Nutrition Board of the National Research Council, and by the Council on Foods and Nutrition of the American Medical Association.* These standards have been very carefully considered and compiled, and, while they may subsequently require revision, stand at present as acceptable to the majority of experts in nutrition in this country. Familiarity with these standards simplifies greatly the practical application of the fundamentals of nutrition. In the application of these standards in terms of foods, particularly for those people with problems because of food habits, because of limitation of income and because of ignorance of food-values, great help can be obtained from dietitians, home economists and nutritionists trained in the practical application of this information. In time a physician will come to look upon the dietitian

working under his direction as an invaluable and time saving agent in filling a dietary prescription, just as he looks now to the pharmacist to fill a prescription for drugs in a manner which largely has replaced the dispensing of drugs by the physician.

(2) *Give leadership in the educational campaign by supporting, developing and guiding the local nutrition committee and campaign whenever and wherever possible, and by personally teaching whenever possible.* Most people naturally turn to physicians for guidance in matters pertaining to health, and this rôle of guidance and leadership must not be forsaken in the field of nutrition, because the physician is too busy caring for those who are sick. There are experts trained in many phases of nutrition, in economics of food and in the preparation and manufacture of them. From these experts the physician may get much helpful advice, but it is he who must assume the positive leadership in a matter dealing with health.

(3) *Encourage the use of foods rich in essential foodstuffs and especially enriched foods, and similarly discourage the promiscuous use of self and loosely administered preparations of vitamins and diets.* Much could be written of the great economic wastefulness of preparations of vitamins. In 1937 the American public spent approximately \$100,000,000 for such preparations, and since that time many more hundreds of millions of dollars have been spent for these substances in various forms for therapeutic reasons, much of them self-prescribed and administered. Our thought of vitamins should be in terms of them as foods, and not drugs, and every effort should be made to satisfy the requirements of vitamins and minerals by adequate diet and not by medicinal preparations of them, the use of which largely should be restricted to the supplementing of restricted diets and to the treatment of disease.

(4) *Be prepared to supplement therapeutic diets, so that adequate standards of nutrition will be maintained.* The use of specialized diets for therapeutic purposes over long-continued periods of time is increasing rapidly. Many limited diets for treatment of diseases of the gastro-intestinal tract, such as peptic ulcer and chronic ulcerative colitis, of diseases of the heart and kidneys, of allergic conditions, and for purposes of weight reduction carry insufficient amounts of the "essential substances." Physicians have observed cases of pellagra, beri-beri and even scurvy brought on by the long continued use of limited diets, and unquestionably many patients have developed less severe degrees of malnutrition while following them. Frequently during pregnancy and lactation it is advisable to supplement the diet to maintain optimal nutrition for the mother and child. Many therapeutic diets need to be supplemented by vitamins and minerals in the form of natural foods sources, concentrates or synthetic preparations of them, preferably the first. For the successful instruction of the patient in the

prescribed diet the services of a trained dietitian may be very helpful, if not invaluable.

(5) *Finally, in nutrition, think of the positive side of medicine, i.e., the attainment and preservation of good health, and not the negative side—the treatment of disease.* Someone has said, "Why ask the physician about health; he knows only about disease?"

If we successfully carry out this nutrition campaign and give it the adequate leadership of medicine we will have accomplished one of the greatest public health movements of all times, we will have continued our positive leadership in health, and we will have taken another definite step forward. And then, as Sebrell² has so well said, we may "Eagerly look forward to the days when our children and our children's children will be armed with the armor of robust health."

490 Post Street.

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GOVERNMENTAL AGENCIES AND MEDICAL PRACTICE*

HARTLEY F. PEART, ESQ.
San Francisco

THE report of the Legal Department is printed in the Pre-Convention Bulletin and I will not burden you with a repetition of any of the matters contained in it. I do, however, desire to call to your attention and briefly discuss a vital development in the field of government which has crept upon us in the past few years and which, if not properly understood, may engulf the profession. I refer to the mushroom-like growth of administrative agencies of the Federal government. In its approach to socialized medicine the profession has for years thought in terms of legislatures, votes, bills, initiatives, elections and all of the things that pertain to the legislative branch of the government.

The profession has been facing the legislative front and thinking in terms of legislative action. It has been prepared to defend itself against legislative attack and it has successfully done so. But, while the profession is facing the legislative front and thinking in terms of legislation, an entirely different attack is being carefully planned and executed by a different branch of government, namely: the executive or administrative branch. Unless the profession

* Supplemental report made to House of Delegates of California Medical Association at the Seventy-first Annual Session, Del Monte, California, May 3, 1942. Reference is made thereto in minutes of H. of D. in this issue. Prior report appeared in Pre-Convention Bulletin, April, 1942, C. and W. M., on page 210.)

abruptly wheels a part of its forces around and faces the administrative threat also, it may suddenly find itself defeated from the rear while it has had its guns trained on the front.

You are all aware of the fact that boards, bureaus, agencies and offices have sprung up in Washington in great number in recent years, but are you aware of just how many there are and how extensive are the powers that they wield. I have here a recent list of Federal government agencies other than the ten executive departments which are headed by Cabinet officers and various independent commissions and boards. I will read the list to you:

A List of Governmental Agencies

Advisory Commission to Council of National Defense
Agricultural Conservation and Adjustment Administration

Agricultural Marketing Administration
Agricultural Marketing Service
Agricultural Research Administration
Army Specialist Corps
Board of Civilian Protection
Board of Economic Operations
Board of Economic Warfare
Bureau of Industry Advisory Committees
Bureau of Research and Statistics
Commodity Exchange Administration
Coördinator of Government Films
Coördinator of Information
Council of National Defense
Defense Communications Board
Defense Contract Service
Defense Homes Corporation
Defense Labor Advisory Committees
Defense Plant Corporation
Defense Resources Committee
Defense Savings Staff
Defense Supplies Corporation
Division of Contract Distribution
Division of Defense Aid Reports
Division of Defense Housing Coördination
Division of Press Intelligence
Economic Defense Board
Electric Home and Farm Authority
Export-Import Bank of Washington
Family Security Committee
Farm Credit Administration
Farm Security Administration
Federal Bureau of Investigation
Federal Home Loan Bank Administration
Federal Public Housing Authority
Food and Drug Administration
Government Printing Office
Joint Mexican-United States Defense Commission
Metals Reserve Company
National Defense Mediation Board
National Defense Research Committee
National Housing Agency
National Patent Planning Commission
National War Labor Board
National Youth Administration
Office for Coördination of National Defense Purchases
Office for Emergency Management
Office for Agricultural Defense Relations
Office of Censorship
Office of Civilian Defense
Office of Coördinator of Inter-American Affairs
Office of Defense Health and Welfare Services

Office of Defense Transportation
Office of Export Control
Office of Facts and Figures
Office of Government Reports
Office of Lend-Lease Administration
Office of Merchant Ship Control
Office of Petroleum Coördinator for National Defense
Office of Price Administration
Office of Price Administration and Civilian Supply
Office of Production Management
Office of Scientific Research and Development
Permanent Joint Board on Defense
Plant Site Board
Priorities Board
Rubber Reserve Company
Solid Fuels Coördinator for National Defense.
Supply Priorities and Allocations Board
United States Information Service
War Production Board
War Relocation Authority
War Shipping Board
Work Projects Administration

All of these agencies are responsible only to the President. They possess tremendous powers and some of them *can* and *will*, and *have* entered the field of medicine in a tremendous degree. How much further they will go depends to a great extent upon the medical profession.

Let us consider briefly those agencies which have so far affected medical practice.

1. FEDERAL SECURITY ADMINISTRATION

We now approach civilian agencies. Federal Security Administration, created by Presidential proclamation some time ago, is the executive agency having control over the United States Public Health Service, the Social Security Board, the National Youth Administration and many other bureaus and offices. Federal control over medicine is *definitely* within its plans and powers. It is achieving that goal quietly and through administrative action and without any reference to the legislative branch of government. Let us consider specific examples:

(a) Social Security Board:

This agency now controls unemployment benefits and old age benefits throughout the country. It has some jurisdiction over health services, as yet very limited, but the Board itself is constantly endeavoring to enlarge its power over medical care and in its recent annual reports has definitely demanded that a national program of compulsory medical care be included in its functions. It is still in the planning stage but don't fail to realize that all bureaucratic agencies constantly strive to extend their power and that the natural direction for the Social Security Board to extend is in the field of governmental medicine.

(b) United States Public Health Service:

The war has caused the concentration of large civilian groups in new housing areas. Medical care in these areas has not been overlooked by the government. On July 1, 1941, Congress appropriated for "emergency health and sanitation

activities" in private industrial plants engaged in defense work and in areas adjoining such plants or government plants the sum of \$1,235,000.00. A few months later another \$2,000,000.00 was added to this appropriation. Both of these appropriations specified that the Public Health Service was to work in conjunction with and under state and local authorities. However, on February 21, 1942, another appropriation of \$1,295,000.00 was made with the express provision that state and local authorities were to have no control whatever. The foregoing appropriations, while not large, are in addition to the regular Public Health Service funds for its normal activities. There is reason to believe that further appropriations will be made if the Public Health Service so desires. With the strings removed, Public Health Service can spend the money as it pleases. It doesn't take much imagination to visualize clinics staffed by government employed physicians in many "defense" areas.

We are not discussing here the necessity of proper medical care and service in housing and defense areas, but our view is that the profession itself can best furnish such care and service, without the establishment of employed staffs of government physicians.

(c) National Youth Administration:

This is a relatively minor matter but, just for your information, the National Youth Administration has statutory power to provide "emergency hospital and medical care" for persons employed by it on public projects.

2. NATIONAL HOUSING AUTHORITY

This agency was recently created by executive order and has control over all of the various Federal housing projects, including F.H.A., H.O.L.C., U. S. Housing Authority, Federal Works Agency, Defense Housing Corporation, W.P.A. and Division of Defense Housing Coordination. So far, only one of its divisions has entered the field of medicine, namely: the Federal Housing Agency.

(a) Federal Housing Agency:

In 1941 (42 U.S. Code, Secs. 1531-1534) Congress gave the Federal Housing Agency power over community facilities in defense public works. Community facilities were defined to include schools, sanitation, recreation and "hospitals and other places for the care of the sick." The law contained a provision that any hospital built through the Federal Housing Agency must not be under the control of the United States or any agency thereof as to operation. However, in actual practice, the agency has used its power to try to force local communities to extend county hospital care to full pay patients in return for construction grants. In other words, the Bureau is using the basic law as a means of forcing socialized medicine wherever it can. A total of \$300,000,000.00 has been appropriated to date

for defense public works community facilities. The next appropriation may eliminate the restriction against government ownership, just as the last Public Health Service appropriation eliminated the state and local authorities. If this is done, we will have a large government bureau nicely entrenched in all housing areas.

3. FARM SECURITY ADMINISTRATION

This agency, which is in the Department of Agriculture, is authorized by Congress to make government loans for "rural rehabilitation." In the fiscal year 1941-1942, \$64,000,000.00 was appropriated to this agency for such purpose. Under its authority the F.S.A. can and does make loans that are earmarked for the express purpose of paying the cost of medical care. As it controls the purse strings it likewise controls the method under which medical care is rendered its borrowers.

4. OFFICE OF DEFENSE HEALTH AND WELFARE SERVICE

This is a so-called planning agency. It may be said to be the brain. With unlimited funds and a large personnel, it is busy figuring ways and means to accomplish whatever it wants to accomplish. Whatever plan it may evolve, you may be certain that it will place Washington in the driver's seat.

The foregoing are not all of the government agencies concerned with medicine, by any means. I have just picked a few examples. It must be understood that it is inherent in the nature of administrative bureaus to reach out for more and more control over more and more things. Furthermore, as bureaus become entrenched legislators become afraid to move against them. Political employees in bureaus are the backbone of political parties and, hence, wield a tremendous power over the elected legislator.

Should not the profession give ever increasing study, thought and action to the end that, in the present war emergency and to meet peace time administrative encroachment, it can continue to furnish medical care upon a proper basis?

111 Sutter.

GRAFTING OF SKIN: ADVANTAGES OF THE PADGETT DERMATOME*

GEORGE WARREN PIERCE, M.D.

San Francisco

THIS paper is presented as an appreciation of the value of the Padgett Dermatome in the cutting of skin grafts: for this machine, designed by Earl C. Padgett, M. D., of Kansas City, Missouri, and introduced in 1938, constitutes the greatest contribution in many decades to the technique of skin grafting.

* Read before the Section on Industrial Medicine and Surgery, at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

ADVANTAGES

The advantages of the apparatus are many. Grafts, four and one-half inches by eight inches, can be taken at any desired uniform thickness, calibrated to one one-thousandth of an inch. Of

inch and is ideal as a covering. However, the percentage of take is so variable, and the difficulty of management so great, that this type has only a very limited application. The donor area must be closed surgically, while that of the deep inter-



Fig. 1.—Skin graft adherent to drum. Also shows how drum is rolled while cutting.



Fig. 2.—Skin-graft being placed over burn. Note even texture of graft.

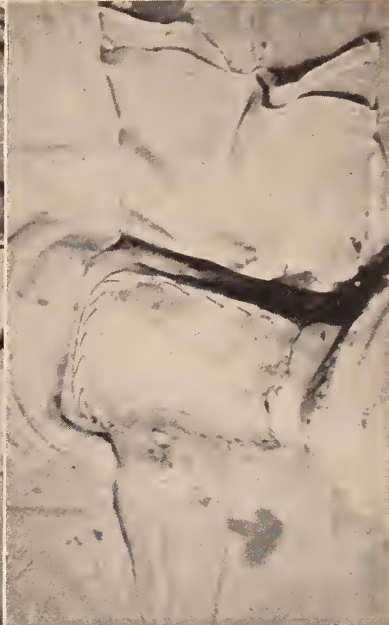


Fig. 3.—Graft sutured into position on leg.

special value is the ability to take grafts from any uneven surface, as the chest, abdomen or back, greatly enlarging the choice of donor areas.

An analysis of types of skin grafts with their advantages and disadvantages is pertinent. The Thiersch graft, the split-skin graft, the deep intermediate graft, and the full thickness graft represent the types. The Thiersch graft (.008 to .010 of an inch in thickness) covers raw areas with a high percentage of success. However, there is a great tendency for it to contract and ridge, and it offers little actual protection against trauma. The split-skin graft of Blair and Brown, with a thickness of .012 to .020 of an inch, consists not only of the epithelium but of a varying part of the corium. It is cut, freehand, with a large knife and varies considerably in thickness. To cut grafts of any size requires expertness of some degree. The grafts have a high percentage of take, and partake of some of the characteristics of full thickness skin, tend to contract less than the Thiersch type, but still do not protect as efficiently as the thicker type, nor do they match well with surrounding skin.

PADGETT GRAFT

The deep intermediate graft of Padgett, cut with his Dermatome, measures .022 to .030 of an inch, relatively seventy-five per cent of the full thickness of the skin. In appearance and protection value it approaches closely to full thickness skin.

Full thickness skin measures .032 to .045 of an

inch and is ideal as a covering. However, the percentage of take is so variable, and the difficulty of management so great, that this type has only a very limited application. The donor area must be closed surgically, while that of the deep inter-



Fig. 4.—Healed burns of both legs. Large individual grafts are readily discernible, nine weeks after grafting.

The Padgett Dermatome consists of a drum with a movable knife fixed at a definite distance from the drum. This distance can be varied at will with calibrated set screws. Rubber cement is applied both to the donor area and the drum. The drum is set on the skin, then slightly rotated to raise the skin a little above the surrounding area, and the knife in its carriage is moved back and forth. A full drum can be taken, or, by simply lifting the drum, the graft can be cut off at any point.

Since the split graft or the deep intermediate

type are selected for grafting almost all raw areas, and since both can be cut with this machine, it has become indispensable to the reconstruction surgeon. After nearly two years' experience with the Padgett Dermotome, the author is enthusiastic about its merits and urges that its use be adopted widely.

The illustrations are of the apparatus in use and some of the author's cases showing the grafts.
490 Post Street.

CLINICAL NOTES AND CASE REPORTS

CONGENITAL ABSENCE OF THE PECTORALIS MAJOR*

CLIFFORD V. MASON, M.D.

San Leandro

AND

LOUIS J. RUSCHIN, M.D.

San Leandro

PARTIAL absence of the pectoral muscles is not infrequent.¹ Bing² estimated that they comprise 28 per cent of cases of congenital absence of muscles. However, Jones³ believes this figure is too high, maintaining that many congenital absences are not as easily detected as the pectoral group.

Complete absence of the pectoralis major is rare. The usual lesion is absence of the sterno-costal portion, with or without absence of the pectoralis minor. The well-developed, curved, anterior axillary fold is absent in these patients, and is only slightly compensated by hypertrophy of any remaining muscle strands. (See figure.) Absence of both major and minor have been reported.^{3, 4, 5} Only one case of bilateral absence has been reported.⁶

Associated congenital anomalies of the homolateral hemithorax and upper extremity are quite common. Rib and costal cartilage defects,⁷ breast defects, (see figure) syndactylism,^{1, 8, 9, 10} shortening of the upper extremity,⁷ brachydactylism,⁷ absence of external abdominal oblique,¹⁰ partial absence of the serratus anterior,¹¹ latissimus dorsi,¹¹ and intercostals¹¹ all have been reported.

Of the several theories advanced as to the etiology of pectoral defects, the most quoted is that of Lewis.¹² He found that in the 9 mm. embryo the pectoral muscle mass is largely above the first rib. In the 11 mm. embryo it extends lower, but it is still undifferentiated into its component parts, and is not attached to the ribs or humerus. In the 16 mm. embryo, the clavicular portion is split off and the remainder then divides into the sternal portion and the pectoralis minor. Perhaps the failure of the primitive mass to attach itself to the ribs and sternum might allow its not becoming differentiated into its normal com-

ponent parts. This coincides with the known fact that the defects are usually in the caudal portion.

REPORT OF CASE

This patient is a 24-year old Japanese male, who was seen in the Lung Clinic of the Fairmont Hospital, in San Leandro, because of tuberculosis contact history. He was asymptomatic. Past history and functional inquiry are entirely negative. Family history, according to the patient, reveals no known congenital defects. Physical findings are entirely negative, except for the absence of the caudal portion of the left pectoralis major, and the left mammary gland. No functional impairment is detected clinically. Fluoroscopy and x-ray films reveal a normal bony thoracic cage. Heart and aorta are within normal limits. The lung fields are entirely clear. From the x-ray alone may be gained the impression of a previous left radical mastectomy.

Fairmont Hospital, San Leandro.

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INTRAVENOUS ANESTHESIA: A PRACTICAL METHOD FOR ITS ADMINISTRATION

JOHN H. GIFFORD, M.D.

Los Angeles

MOST anesthetists have developed a technique of their own for the administration of intravenous anesthesia, so that their hands are partially freed. When intravenous anesthesia first became popular, its administration was considered to be a two-man job; one to administer the anesthetic and the other to support the patient's chin and administer oxygen when necessary. Its administration can be simplified by the intermittent injection of the drug directly into the rubber tube of an intravenous infusion, but the routine use of this method is not justified because of its cost. Several ingenious mechanical devices have been developed to simplify the administration of intravenous anesthetic, but none of these are on the open market.



Fig. 1.—Showing application of the method.

(Continued on Page 59)

* From the Fairmont Hospital, San Leandro.

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* * *

FOREWORD: AN EXPRESSION OF APPRECIATION

The Tuberculosis Associations are deeply appreciative of the courtesy extended by the California Medical Association in making it possible to present to the readers of CALIFORNIA AND WESTERN MEDICINE the papers read before the 1942 annual meeting of the California Tuberculosis Association and the California Trudeau Society. It is hoped that this presentation will be of value to the physicians of the State.

The Tuberculosis Associations of California are anxious to coöperate at all times in giving whatever service is possible to the medical profession, to the end that our community health may be brought to its highest level.

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ORIGINAL ARTICLES

EVIDENCES OF TUBERCULOUS INFECTION IN PEOPLE DYING OF OTHER CAUSES THAN TUBERCULOSIS*

HENRY C. SWEANY, M. D.

Chicago

THE length of time of survival of the tubercle bacillus in the human body, a debatable problem since the work of Naegeli and Von Behring, respectively, resulted in a controversy near the beginning of the century. There was no question about Naegeli's observations, which have been supported by Orth, Beitzke, Opie, Schurmann and others regarding the presence of calcified lesions in practically all lungs of people dying of other conditions than tuberculosis. Whether they were "healed," as many thought, or how many contained living bacilli, were two phases of the problem that were not soon solved. But as time passed the infection rate for most countries gradually decreased, due largely to preventive measures. As a result, the number of such calcified lesions has decreased until in many districts today no more than half of the lungs contain them.

Von Behring's theory regarding the prolonged endogenous progression from childhood to adult life, however, was not so certain. The theory of bovine origin was surely not borne out in any more than a small percentage of cases, but Von Behring's ideas could not be treated lightly. As with so many problems in medicine there was much truth in his contention; the difficulty was apparently due to an incomplete knowledge of all conditions. Doubtless Von Behring actually saw some childhood infections ripen into disease in adult life; but the life time span of the disease is not the common type of endogenous progression. The span of disease rarely extends from childhood to adult life; often extends from childhood to puberty, or from puberty to college age. Many times, particularly in Naegeli's time, there was complete healing in childhood and reinfection in adult life.

The solution of the problems arising out of the apparent paradox was sought by every available means. The first efforts were devoted to seeing how many old lesions described by Naegeli contained bacilli. By inoculating the material into animals, Rabinowitch reported finding living bacilli in nearly half the calcified lesions and in

about two-thirds of soft or chalky lesions. Loomis, Schmitz, Kurlow, Wegelin, and Lubarsch obtained comparable results. Opie and Anderson, however, reported positives in only about 30 per cent of all cases. They made pertinent observations also, overlooked by their predecessors, that most soft apical lesions contained tubercle bacilli, but rarely did they find the bacilli in focal calcified lesions elsewhere unless the apical lesions also contained them. To support these findings they reported 45 per cent positive results in lung tissue away from all focal tubercles, apparently bearing out the contention of Theodore Smith, Weichselbaum and Bergel that bacilli can live for long intervals in the lungs without causing any tissue reaction. Herbitz, McConkey, MacFadyen, Loomis, Pizzoni, Spengler, Straus, Wang and others reported similar observations for lymph nodes free of tubercles.

Recently Feldman and Baggenstoss reported the surprising positive findings of only four per cent of focal tubercles in children. Much of their material, however, was shipped to them in borax which may have been detrimental to some of the bacilli. Besides, when so many were selecting the material, there would not be a tendency to uniform sampling. Many of the less dense lesions may have been overlooked. The disparity, however, is certainly not entirely on such a technical basis. The facts seem to point more to a different type of material than was used before. Tubercles in children perhaps differ from those of older people. When such tubercles become encapsulated, most of them go on to healing and rather early sterilization. But if we accept their results at their face value, there is still the unsolved problem of lesions that produce disease later in life.

From pathological studies, Birsch-Hirschfeld in 826 accidental deaths, reported that 20.7 per cent had tuberculous lesions with 4.2 per cent of them active. Reinhard found 36.1 per cent of the lesions "not healed" of 360 adults; Hart found 7.2 per cent active lesions in 573 soldiers; while the largest series of all was that of Robertson, who found 4.05 per cent active lesions in the 2.69 per cent with tuberculosis as the principal cause of death in 3306 autopsies at the Mayo Clinic. This work is significant because it is on a large series and the patients were representative of the whole country.

Clinically there have been numerous reports, most of which are well summarized by Sayé. Active disease (adjudged largely on x-ray examination), ranges from less than one per cent in America and many parts of Europe, to eight per cent in some parts of China. Recently Tice and associates found 4.3 per cent in a survey in a heavily infected district in Chicago.

As evident from the figures cited, as well as many more reports in the literature, there is a great deal of discrepancy in the findings, irrespective of the source or branch of science used to obtain them. They are perhaps due to differ-

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.

From City of Chicago Municipal Sanitarium, Research Laboratories.

Assisted by S. A. Levinson and Asya Stadnichenko (deceased), University of Illinois and Research and Educational Hospital.

ence in concept, difference in material from place to place, and especially from one era to another, and differences in training for a particular objective. For example, as Naegeli's technique improved, his percentage figures rose for positive findings from 75 to 90, to 97 and 98 per cent respectively. In fact, most people in that time must have had gross infection. Obviously there are less infections and less severe infections today than in Naegeli's time. With Naegeli's best technique today, it would not seem possible to find more than 70 per cent of our cases positive. The post mortem x-ray adds to the ease of finding very small lesions.

Another discrepancy in the early reports is in "active" lesions. Most pathologists found four to five per cent of their material positive, but here again figures vary widely; as pointed out by Opie, for clinical appraisal, the differences between latent and clinical tuberculosis have "no other basis than the limitations of diagnostic methods and the tendency of tuberculosis to proceed to recovery." The same indefinite line of demarkation also exists between the concepts of pathological activity. Some may call a lesion active with a thin capsule, others only with perifocal giant cells, while still others might demand soft caseous lesions. Roentgenological criteria of activity is even less accurate than either pathological or clinical.

One absolute criterion alone remains, viz: living tubercle bacilli *in* the lesions. Even this must be supported by collateral pathological findings such as a thin capsule, giant cells in or near the capsule, otherwise the bacilli may be from recent exogenous sources and may not lead to disease. *The presence of lesion-producing bacilli, however, is prima facie evidence of potential disease.*

Due to improvements in technique and by using every available means at our disposal, it was thought feasible and justifiable to try to clear up some of the discrepancies existing in the reported results of the past, and to discover any clues with respect to the exacerbation of the disease.

The present study was, therefore, planned to achieve that aim, although it was nearly ten years before it was an unqualified success. During the intervening time, several different attempts were made with meager or inconclusive results. The material was always difficult to obtain in sufficient quantity. Such a result is to be expected when it is necessary to depend upon people having no special interest in the work. Of 45 acceptable cases of these various attempts, however, five had positive cultures (11.1 per cent), a result that was an encouragement to further effort. The various attempts to carry out the work did help to develop a trained organization and a standardized technique which has contributed largely to the success of the venture. The work was finally reorganized about a year and a half ago with new objectives, a stabilized personnel, and an assurance of abundant material.

OBJECTIVES

The prime object of the work was to attempt to discover the incidence of infection as it exists today in people apparently well; the incidence of the disease in ill people but not having had a diagnosis or any recognized symptoms of tuberculosis; to see if anything could be determined regarding the mode of development of the disease; to see if the development of the disease could be related to any state or condition of the host with regard to age, race, sex, occupation or intercurrent diseases; to see if any means might be used during life to discover dangerous lesions by studying of histories, and from physical, x-ray and laboratory findings. In addition it was desirable to find if possible the relation of the presence of tubercle bacilli to the age and character of the lesions and to other disease processes and to pathological evidences of active tuberculosis near and away from the focal lesions. Finally, it was desirable to find the comparative value, if possible, of different culture methods, acid-fast staining, and fluoroscopic microscopy in the identification of the presence of living bacilli in tissues.

FACILITIES AND ACKNOWLEDGMENTS

As might be inferred from the preceding discussion, it was most important to have an uninterrupted flow of material, suitable laboratories with adequate supplies, and corps of trained workers.

The laboratories at the Municipal Tuberculosis Sanitarium afforded the facilities for carrying out the work, including bacteriological, pathological, x-ray equipment, and the materials necessary for these various operations. These facilities were made available by the authority of the Board of Directors, Dr. Frederick Tice, President; Mr. Harry Reynolds, Treasurer; Dr. Richard Davison, Secretary, and Dr. Leo M. Czaja, Superintendent of the Institution.

Much of the material was furnished by the Cook County Hospital Pathological Laboratory with the cooperation of Drs. Jack D. Kirshbaum and William P. Mavrelis. The Coroner's Pathological Laboratory and the Research Hospital Pathological Department also furnished much valuable material for study.

Special aid was also obtained from the Tuberculosis Institute of Chicago and Cook County.

The technical part of the culture work was carried out or supervised by Miss Asya Stadnichenko until she was forced out by illness and an untimely death. Since then her assistants, Messrs. William I. Lansford and John M. Kleeck, and her sister Miss Vera Stadnichenko have carried on with no more interruptions than could be expected following such a misfortune.

The pathological section work has been carried out by Miss Alma Everett and her assistants.

The post mortem x-ray and liaison work has been done by Mr. Tom Cantalancio.

The photographs and illustrations have been

prepared by Mr. William L. M. Martinsen.

METHODS

The method of procedure was so organized that no two groups could know the results of any other until the final reports were obtained. The lungs were removed and x-rayed; the various lesions suspected of being tuberculous were charted on a stamped outline of the lungs. Each lesion was given a number. Any extra-pulmonary tuberculosis (and other disease) was also recorded. The various tuberculous lesions were then removed with sterilized instruments and placed in sterile bottles bearing the proper number of the tubercles on a label. The culturing process was carried out with sterilized equipment. The individual lesions were removed from the bottles by sterile forceps; the excess tissue was trimmed off and cultured for most of the first 200 cases. The practice was discontinued for reasons to be given later on in the work. The tubercle, with a small amount of tissue around, was cut in two with sterile scissors, one-half being placed in formaldehyde solution for section and the other in a sterile mortar and ground into an impalpable powder or magma for culture, smears and animal inoculation. The contents of the covered mortar were taken up in sterile salt solution and treated in the standard manner NaOH, HCl, or C_2H_{204} (and sometimes two of these substances) and planted on two to five culture bottles of three or four different media. The culture medium used was that of Saenz, Loewenstein's, modified by Jensen and Holmes, Wooly-Petrick, and sometimes a modified Sweany-Evanoff medium and Arena's medium. Each soft or semi-soft lesion was worked up separately and cultured. At least one guinea pig was used on the fresh lesions for each case. Old dense lesions of the same side were frequently pooled. The cultures were observed weekly after three weeks and were not rejected until six months' time had elapsed. The animals were killed and reexamined after sixty days.

The specimens for pathological section were decalcified and stained first with H and E, but all tissues positive on culture were sectioned, stained and examined for tubercle bacilli. Many times recuts and partial serial sections were made.

The microscopical pathological examination included a detailed description of the pathological formations in the section with a rough estimation of the age of the lesions as outlined in a former study. Owing to the fact that half of the lesion was taken away from culture and usually only one section was examined, the analysis was less accurate than in previous work. As later results show, however, there was an interesting relationship of age to the number of positive cultures. The smears were examined completely for acid-fast bacilli on early type lesions. All old lesions were studied for at least fifteen minutes as routine.

All of this work was done without any knowledge concerning the patient. All of the clinical, pathological and x-ray data was compiled by another team of workers and the various findings finally fitted into a master chart.

EXPERIMENTAL RESULTS

This preliminary report involves only the first 300 completed cases of 800 cases already partly worked up.

Table I shows the division of the cases on the basis of the presence of, or the type of calcification. There were 37 lungs without any calcified lesion at all; and 51 in which the lesions were too small to divide successfully with scissors. The total of 88 unstudied specimens was 29.33 per cent, leaving 212 (70.67 per cent) that were studied. There were 23 cases in which no lesions were found having age characteristics suitable for analysis. Some were silicotics; others had "silicotic fibrosis" or other evidence of pneumoconiosis. Some were chondromas, or other calcified pathological lesions than tuberculosis; others were "fibroid caps"; while a few were not suitable for age analysis at all.

The results of search for evidence of tubercle bacilli in the 212 cases studied, are shown in table II. Acid-fast bacilli and positive cultures are compared and both are combined. There was 10.38 per cent positive for acid-fast bacilli, against 16.53 per cent positive cultures. Both together gave a positive finding of 20.75 per cent. There were 14 cases in which both were found positive; 21 positive on culture, but negative on smear; and 8 positive on smear but negative on culture. The total number of colonies averaged about ten times as many as there were acid-fast bacilli found. Since there was about ten times as much material used for cultures as was used for smears, the results were fairly comparable. There was not always agreement, however, of pathological lesions with positive culture and smears. It must be remembered that the parts saved for section were not cultured, and vice versa, and that many times tubercles have "budding" colonies only on one side. Furthermore, the sections made involved only one small portion of the half for section, while the culture represented practically all the half that was cultured. It may also be possible to have positive cultures without evidence of recent tubercle formation. Bacilli may possibly live for some time entirely encapsulated. The results, however, seem to indicate that the average time of survival isn't long, without producing tissue reaction.

In table III are arranged the 189 cases on which age analysis was possible on at least one lesion, with the positive findings recorded of the youngest lesion immediately below the percentages in the third line. In line four are cases having slight silicosis and line five are the corrected figures.

Outside of the cases having one or more silicotic lesions, the bacilli disappeared from tubercles rather rapidly and at a regular rate. Although

a few cases seem to show life in tubercles up to 10 years, the evidence indicates that enclosed lesions do not retain living bacilli long after two years and many become sterile after one year. The apparent persistence of the bacilli is due to the "spreading," "overflowing," or otherwise progressing lesions. Sometimes it may be confined to only one tubercle and even only a small part of one tubercle, but in such cases the bacilli escape the tubercles to lie dormant in the outer capsule or in the tissue beyond for long, or to form into new colonies which become encapsulated. The fact that we haven't always found the fresh colonies does not argue against their existence, because we only observed a small percentage of the surface of any one tubercle. One-half was cultured and a section was made of the other half that represented only a small per cent of all the surface.

The question of what causes the bacilli to survive or what causes the tubercles to weaken and disseminate the bacilli, is largely unanswered. It was at first suspected that silicotic fibrosis may be a dominant cause, but although high, a higher percentage of positives resulted from "ruptured" or "overflowing" lesions than from those having silicosis or "silicotic fibrosis." The only significance of small areas of silicosis appears to be that they afford a "hide out" for the bacilli. Disease comes only after a critical quantitative threshold is reached.

Positive findings of pathologically active tuberculosis were present in three cases (1.41 per cent) of the 212 cases studied. One case was an old healing fibroid, another a progressive fibrocaseous infiltrate, and a third a miliary and acinous-nodose progressive tuberculosis in a child. This figure is low, because obvious and advanced tuberculosis was not given to us, and represents quiescent lesions only. In addition, there were 22 (10.38 per cent) cases in which there were definite evidences of progress of the disease around one or more of the calcified lesions as an overflowing or otherwise slowly progressive process. Of these 22 cases, 12 (54.54 per cent) have positive cultures. Only two of these lesions were of a silicotic nature. The cause of occult progression is still enigmatic. The bacilli may have gained more virulence; the host may have a temporary depression in resistance or an accident, disease, or drinking bout at a critical moment in the existence of the lesion.

The group of silicotic cases was of absorbing interest, not only from the standpoint of industrial medicine but more important from the mechanism of survival of the bacilli. The results are charted in table IV. There was one case of second-stage (diffuse type) silicosis, and two cases of typical first-stage silicosis, all of which were positive. Practically every lesion was positive with numerous colonies and acid-fast bacilli in smear. There was one case of silicotic fibrosis rather marked in some of the hilum lymph nodes, but no cultures were found positive. There were

11 cases with a few whorls of silicotic fibrosis in one or more lesions, two of which were positive, and 15 cases of similar type lesions except there was either much coal or iron pigment, or evidence of tuberculosis caseation present in addition. Five were positive. In 30 cases having slight or moderate silicosis 10 were positive (33.3 per cent).

The interesting feature was that in *none* of the "silicotic" lesions could there be found any recent signs of tuberculosis activity. The bacilli seemed to harbor in the old nodes and produce slight caseation and an "egg-shell" calcification but no cellular reaction. Perhaps the defense mechanism may have become exhausted within the nodules or the bacilli may be able to live without increasing much in numbers (until later in the disease). While the bacilli may survive in the lesions, there do not appear to be any more cases develop active tuberculosis than in other cases. The presence of bacilli, however, is admittedly a threat, but there was a lower percentage of positive findings in the silicotic types than in those showing incidence of a progressive disease. There seems to be a considerable degree of silicosis necessary before a progressive tuberculosis can develop.

Case No. 293, a first-stage silicosis, had lesions that were hard and fibrotic with very little tuberculosis in spite of strongly positive cultures. Case No. 169 was more tuberculous but still not caseous in an 84-year-old man. Had he lived twenty more years he might have died of silicosis.

Several things seems certain: Silicosis can develop without tuberculosis, but when tubercle bacilli come in they tend to remain for long intervals without eliciting any proliferative tissue activity or without appearing to grow extensively until the fibroid tissue "hideout" for the bacilli becomes extensive. Then the bacilli seem to be able to come out in the open and produce disease. All the implications of these observations, however, must await a final review of the whole series of cases before any final judgment can be passed, if then.

The same phenomenon of "dormant" bacilli seemed to exist in cancer tissue. Of five cases in which cancer tissue was found, two (40 per cent) were positive. The same principle may operate as in silicosis, viz: bacilli may survive in cancer tissue, but not grow. There is perhaps no tubercle-forming tissue in the cancer.

In a few cases of old fibroid lung tissue there also seemed to be living bacilli without tubercle. This fact was pointed out by Opie when he obtained growths in lung tissue around tubercles more than in the lesions themselves. It raised the question in his mind whether most of his infections were not coming from outside sources and not from the tubercles. While there is no doubt about a "tissue immunity" existing around tubercles or an "exhaustion" of the resisting forces as the old focus is approached, it cannot explain all the many lesions within the capsules nor the increasing of positive findings as the lesions de-

crease, in age. As in silicosis, in some cancer cases and some old fibroid lesions, there is a nominal percentage of bacilli from exogenous sources. In the oldest lesion groups there was a small percentage of positive findings. There are still residue infections, however, in the old tubercles that gradually diminish as the years pass. Some die out soon (perhaps as soon as one year) but a few by microscopic extensions persist for as long as five years or longer.

In this preliminary report many important details must be omitted, but a few general observations may be made. For example, there was a strong evidence of exogenous reinfection in 12 cases (5.9 per cent); seven (3.3 per cent) had clear-cut "reinfection complexes." Naturally there were more reinfections than this, but just because there happen to be soft lesions in the apexes and calcified lesions in the bases or at the hilum does not prove exogenous reinfection. Many times definite progression from one lesion to another can be traced (as in x-rays No.'s 225 and 235). One of the problems of this study has been to work out a rational means of tracing such infections in the body. Where the ages of the lesions are not widely different and where living bacilli can be found in the older lesions or the giant cells in the capsules, there is no justification in saying the soft lesion is from exogenous sources. It *may* be, but many times endogenous infection can be established without difficulty. Here again we are forced to wait for the complete and final study.

An important collateral observation was that in cases having signs of generalization, no living bacilli were found in any of the lesions. In two of the cases the lesions were less than two-year types, and two more were less than four. In these four cases giant cells were present in many of the lesions, but no positive culture or animal inoculation was obtained in spite of the fact that from 10 to 20 lesions were studied from each 10 guinea pigs and 242 culture bottles inoculated. It seems to suggest that mild generalization produces an unfavorable environment for tubercle bacilli. The findings are shown in table V.

Another important finding is of special interest to roentgenologists. There were 4.29 per cent calcified focal lesions that proved not to be tubercles, not including calcified bronchial cartilages. Among these, were four chondromas; two osteomas (these may have been very old tubercles); one calcified lipoma; one fibroma; one phlebolith, and one case of ossified fibrous tissue in an old fibroid apex. The last lesion showed ossified blood vessel walls and ossified hyaline connective tissue.

While there were many other minor pathological features of interest, there has been no attempt made to correlate the roentgenological findings or the clinical histories. That interesting data will be given in the complete report, together with a more exhaustive discussion of the results

and their significance.

SUMMARY

A study has been made of lesions in the lungs and related lymph nodes of 300 patients dying of other conditions than tuberculosis.

Positive cultures were obtained in 16.53 per cent of 212 cases in which detailed studies were made. Of the same group, only 10.38 per cent showed acid-fast bacilli on smears, but they were not identical, as 21 cases (47.72 per cent of all positives) were positive on culture and negative on smears, and eight (18.18 per cent) were positive on smear and not on culture. Both methods together gave a positive result of 20.75 per cent.

When arranged according to the ages of the lesions there was a positive finding of 80 per cent of lesions less than one year, and a gradual drop of 23.1 per cent at the end of ten years. By deducting cases with silicotic or other interfering lesions, it causes the curve to reach an "irreducible" minimum much sooner. The presence of bacilli in the younger lesions is thought to be due to persistent and "overflowing" lesions, and to silicosis, cancer, etc. In a certain definite number of all lesions, and all "old" lesions, "dormant" bacilli are present from exogenous sources. The conclusions from all of these observations must await more seasoned study.

In seven cases where partial generalization occurred, no bacilli could be found in spite of the fact that in four of the cases the lesions were less than four years, and two had lesions appearing less than two years. It seems to offer a problem for immunologists.

Lesions having "budding" tubercles, "overflowing," or ruptured capsules, or giant cells in or just outside the capsules, contained more bacilli than in any other type.

Silicotic lesions or lesions having slight "silicotic fibrosis," were prone to contain tubercle bacilli more than the average lesions (33.3 per cent). This feature loses its principal significance since it is impossible to estimate the age of silicotic lesions.

Most tubercles gradually heal, beginning after a few months and continuing for seven to ten years, depending chiefly upon the number and persistence of the preceding changes.

There were 4.29 per cent of the "dense" calcified or partially calcified lesions which were not tubercles or silicotic nodules. They were chondromas, osteomas, lipomas, fibromas, phleboliths, etc. It illustrates the need for roentgenograms to study relationships and characters of densities in lung roentgenograms.

Tuberculosis control is a vital part of national defense, according to recent statements of the surgeons general of the U. S. Public Health Service, the Army and the Navy.

FEATURES OF THE EARLY PULMONARY INFILTRATION *

J. BURNS AMBERSON, JR., M. D.

New York

THE greatest obstacle to understanding the behavior of the earliest lesions of pulmonary tuberculosis is their failure to sicken the host. Since, next to absolute prevention of infection, identification and proper management of the early lesion is the most effective means of attack on tuberculosis, the importance of a systematic study of groups of healthy people, among whom the disease may be expected at some future time, can easily be seen. Most published reports include observations of lesions by the x-ray while they are still undetectable by other methods. At Bellevue Hospital a study has been under way for more than thirteen years; the views which I am expressing here are based largely on this experience.

It has been variously stated that a person is unlikely to become a phthisic if he has passed the age of thirty or thirty-five without a demonstrable pulmonary lesion. If we except older people whose resistance has been depleted by uncontrolled diabetes, dietary deficiencies, alcoholism, and the like, the statement holds. Furthermore, it is observed that the lesions of progressive pulmonary tuberculosis usually do not appear until after the start of adolescence. In other words, it is the span of life between adolescence and the early thirties which may be watched with the best prospect of detecting the first appearance of these lesions.

How quickly a lesion may appear in a lung which previously was healthy on x-ray examination is still not very clear. To answer this nearly accurately would require an x-ray examination of a group of healthy young people every week for a number of years; obviously, an objectionable undertaking. However, certain implications are observed. Also, we are not prepared to say much about the relation of the early lesion to recent primary infection. In contrast, with young children, a peculiarity in young white adults, who were tuberculin negative, then became tuberculin positive, and still later developed pulmonary lesions, is the failure to demonstrate by x-ray a typical primary complex; visible enlargement of the regional lymph nodes usually is lacking. Consequently, because the frequency of tuberculin testing must be limited, it is seldom possible to judge clearly whether the lesion discovered is primary, or whether it represents an extension from the primary or an exogenous reinfection.

As to the pathological nature of the early lesion one must depend chiefly upon the interpretation of roentgenographic densities; this must be done with considerable reservation. In a relative mi-

nority of instances the pulmonary field, which on previous examination was clear, contains a new, round, discrete, nodular shadow, usually less than a centimeter in diameter, which conforms with that of a productive tubercle. This appearance may be deceptive because the roentgenographic density of small exudative lesions at their start may have little of the collateral haze which is one of the signs of this type of reaction; i.e., there may be a well defined border indicating the limitation of the inflammatory exudate within bronchobulbar walls rather than the periphery of a productive tubercle. The confusion is not so great in lesions more than a centimeter or so in diameter; first, because the larger the size, the more likely is the process to be wholly or partly of an exudative lobular pneumonic nature; second, because larger lesions usually cast shadows with soft hazy borders. Autopsy of many chronic tuberculous subjects verified the reliability of these criteria, by studying recent lesions of bronchogenic origin, the duration of which is fairly well known from antemortem observation. Thus, the conclusion: most early lesions are predominantly exudative.

Age and race have an important influence. The younger the subject, the more likely is a newly developed lesion to be exudative; this is somewhat more striking in adolescent girls than in boys, and in Negroes than whites. So many observations point this way that one is prompted to utter dictum: until careful observation proves otherwise, assume that a tuberculous lesion, newly developed in the lung of a previously healthy person, is an exudative infiltration and, therefore, potentially very unstable.

The term, infiltration,¹ is aptly applied to the exudative lobular pneumonic or bronchopneumonic lesion. Morphologically, it has the same connotation now as it had when first used by Laennec to distinguish it from the tubercle. The distinction is fundamentally important because of the different potentialities. Whatever the underlying cause may be, the productive (miliary or conglomerate) tubercle tends to follow a mild and indolent course, enlarging and undergoing caseation and excavation slowly; whereas the infiltration (gelatinous or gray) is much more labile, frequently spreading and breaking down rapidly. Similarly the infiltrate may become absorbed much more rapidly than the productive tubercle; or the serous and cellular elements at the periphery of the infiltrate may be absorbed while the liquefied caseous center is excavated.

In retrospect, one may find in a previous roentgenogram a tiny focus which presumably may have been the precursor of the early infiltration, but, without a knowledge of subsequent events, the diagnosis of tubercle, rather than blood vessel, would have been highly imaginative. Nevertheless, there is much to suggest that many recognizable early lesions are in reality extensions from preëxisting occult foci. What we call "early" applies only to that which is demon-

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 11, 1942.

From Columbia University College of Physicians and Surgeons, New York City.

strable. It is a relative term which once referred to the lesion initiating symptoms, but now, to that casting an identifiable roentgenographic shadow.

Knowing that exudative infiltrations inevitably change progressively or retrogressively, we have paid particular attention to the later evolution of those discovered early. The dominant trend of extensive pneumonic infiltrations to caseation and excavation has been noted by clinicians generally. Small early infiltrations behave in a similar way, the one apparent difference being quantitative; central necrosis is the striking tendency. This is so common as to suggest that almost all early lesions are caseous at the center by the time they can be diagnosed by x-ray. The cavity, when present, is often so minute that it can scarcely be recognized in the roentgenogram; special techniques may be required. That the pinhead or pea-sized rarefactions usually denote excavation is verified by their later enlargement and, as a rule, by the demonstration of tubercle bacilli in the scanty sputum or in the gastric washings upon meticulous examination.

The behavior of the periphery of the early infiltration is conditioned largely upon the rate and extent of the central caseation, the apparent reason being that the former depends upon the rate of manufacture in and local diffusion of toxic substances from the latter. If caseation is minimal and sloughs out early, the peripheral exudate is likely to be absorbed rapidly, and the minute cavity may close promptly; secondary bronchogenic lesions are slight or absent. If caseation is rapid and extensive, peripheral extension is greater; when the liquefied matter is discharged into the bronchial tubes extensive, even lobar pneumonic, secondary lesions may result. If caseation is small or moderate in extent (usually not more than 1 or 2 cm. in cross-section) and becomes arrested with little or no ulceration into the bronchus, the peripheral exudate may be gradually absorbed and organized, encapsulating the cheesy residues; roentgenographically, these often have the appearance of so-called "round infiltrates."

The rate and succession of these changes varies greatly. At the start of our study the usual routine of making roentgenographic observations once a month or so was followed. Soon it was found that some lesions changed markedly in this interval. Now it is routine, upon discovering a newly developed lesion in a previously healthy person, to make the examination every week during the first one or two months. Occasionally an interval of several days is the limit. It has been discovered, especially in adolescent and young adult patients, that a cavity, 2 or 3 cm. in diameter, may appear within a week; and infiltration 1 cm. in diameter may double or triple its size in one to four weeks; an infiltration 1 to 2 cm. in diameter may abruptly discharge its liquefied caseous contents into the bronchi, thus incit-

ing an acute tuberculous lobar pneumonia within two or four weeks. Some early infiltrations remain stationary for weeks or months, then rapidly change with excavation and numerous and extensive secondary lesions. The transition from the early lesion to advanced bilateral disease, in exceptional cases, is a matter of only a few weeks. Resolution, when it occurs, is slow. At first the peripheral exudate, perhaps quite serous, may absorb rapidly but as a rule the process slows as the core of the lesion is approached. In several months minute residues remain, almost naked caseous remnants which may be visualized as collections of myriad organisms, delicately imprisoned, waiting for some passing disturbance to spread them far and wide. The warm, fertile lung is ever receptive for the threatened dissemination. During the subsequent two years, approximately, circumstances decide whether wide destruction is initiated, whether the slow process of fibrous encapsulation may become competent and permanent, or whether an indecisive balance between the forces of destruction and repair leaves the lesions in that uncertain and sad state, known as chronicity.

A most interesting observation is the lag between pathological morphological change and systemic effects. For example, upon first discovering an early infiltration the erythrocyte sedimentation rate usually is reported normal. During the subsequent few weeks a steady or intermittent extension of the lesion, perhaps the excavation, may occur without any coincidental change in this test. Then as the pulmonary involvement continues the sedimentation rate for the first time is accelerated; a few days or weeks later the initial fever may be detected. One may interpret this to mean that the diffusion of toxins must persist and reach a considerable level before the systemic effects are measurable by the ordinary clinical and laboratory tests. In some cases tubercle bacilli are discovered in the sputum before these effects are detected.

Certain implications are suggested. In all probability a tuberculous infiltration may develop in the lung within a few days to several weeks. That this may be the first demonstrable extension from a preëxisting occult focus cannot be denied.

When an infiltration is fresh, with only minimal central caseation, the possibility of resolution and complete healing is greater than it is at any subsequent phase of the disease. Conceivably, conditions would be more favorable if the small caseous core had been extruded, but this seldom occurs without some infection of the surrounding parenchyma.

The opportune time for securing maximal effects of treatment is in this early phase, preferably before there are any severe systemic symptoms and before secondary bronchogenic lesions have had time to develop. To wait for the lesion to give indubitable evidence of its "activity" usually means that the best opportunity for cure

has been lost. Fortunately, this does not imply that an "arrestment" may not occur later. But, to accomplish the most for the patient, the fact must frequently be emphasized and well remembered that a small lesion, demonstrable only by x-ray and wholly symptomless, may be an early infiltration with serious and closely impending potentialities. Unless it is unmistakably fibroid, such a small lesion at the start should be observed roentgenographically at weekly to bi-weekly intervals. Preferably, the patient should be on rest treatment while this is done. These conceptions have proved, in our experience, to be a sound basis of treatment with results surpassing any other scheme which we have tried. The experience seems to indicate that, if the conceptions could be applied generally, tuberculosis would seldom become the advanced and fatal disease with which, regrettably, we are so familiar.

SUMMARY

The behavior of the earliest lesions of pulmonary tuberculosis can be understood only by a systematic study of apparently healthy people among whom the disease may be expected to appear. The period of life between the start of adolescence and the age of thirty or thirty-five is the time during which most of these lesions first develop.

Most lesions of the early infiltration are a predominantly exudative, lobular pneumonic character; this type of tissue reaction is most conspicuous in adolescents, especially in young girls and in Negroes. The assumption should be made, until well proved otherwise, that this type of reaction prevails, remembering that the roentgenographic appearance may be misleading.

The striking tendency of the early infiltration is to progress to the point of caseation and excavation. Close study demonstrates that such changes may be rapid; e.g., a small lesion may enlarge, caseate, and slough out within a week or two, and give rise to extensive secondary bronchogenic lesions.

Usually, systemic effects such as fever and an accelerated erythrocyte sedimentation rate, are not apparent at the time of the early infiltration and there is often a considerable lag in these effects while the lesion is advancing.

It may be inferred that the early infiltration may develop within a few days or weeks in the lung of a previously healthy person. There is reason to believe that in many or most instances there have been preëxisting occult foci which served as points of origin.

Treatment is most successful if it is based on these conceptions; usually, advanced tuberculosis can be avoided.

HAEMOTOGENOUS PULMONARY MANIFESTATIONS IN EXTRAPULMONARY TUBERCULOSIS*

LEO TEPPER, M. D.
Los Angeles

TO determine the form of pulmonary pathology existing in association with extrapulmonary tuberculosis, the chest films of 100 unselected patients with extrapulmonary tuberculosis were analyzed.

For comparison and in order to weigh the practical import of results, another 100 cases of routine adult pulmonary tuberculosis, with no evidence of extrapulmonary foci, were reviewed.

In the group of 100 patients with extrapulmonary tuberculosis, 79 showed x-ray evidence of post-primary pulmonary involvement. In 21 of the cases there was no x-ray evidence of a post-primary lesion and in only eight of these there was evidence of primary involvement. Although a certain percentage of primary lesions are hidden behind the mediastinal structures and the domes of the diaphragm, and some of them may have resorbed completely, there is also the possibility of some portal of entry other than the lungs. At any rate the absence of a pulmonary post-primary or primary tuberculous lesion does not necessarily exclude an extrapulmonary focus.

The majority of the pulmonary lesions in the 79 cases were fibrotic and calcific, apparently inactive; proliferative, nodular, and exudative manifestations were decreasingly common in that order. A miliary distribution of lesions was seen in 12 instances, seven of these being acute miliary generalizations and five of chronic nature. Lesions interpreted as of fibrotic character were seen in 37 patients and in 24 of these fibrosis was the predominant feature. Calcification was observed in 35 instances and in 12 of these it was the predominant lesion. The character of these lesions and the tendency toward bilateral, symmetrical, apical and subapical distribution, seen in 44 of the 79 cases indicates a haematogenous origin and emphasizes the systemic nature of the disease.

There was roentgenographic evidence of cavitation in 15 patients. These cavities were mostly thin walled with bilateral symmetrical distribution. In spite of the fact that in 12 cases the sputum was positive for tubercle bacilli and that these patients had pulmonary symptoms, only one had evidence of bronchogenic spread.

In cases in which multiple films were available, stability or regression of the pulmonary lesion and absence of bronchogenic spread were the outstanding features. This was true even of those cases where cavities were present. Though progressive pulmonary lesions did occur, for the

1. The term "infiltration" refers to the *process* by which the tissue is invaded by tuberculous inflammation, while the term "infiltrate" is used to indicate the lesion produced by the process.

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Abstract.
From Los Angeles County General Hospital.

most part they were of haematogenous origin.

Of the cases with but one chest film available, the majority were interpreted as of chronic nature.

The following features, as determined from this study, may be listed as characterizing the pulmonary pathology associated with extrapulmonary tuberculosis: (a) Predominance of fibro-calcific lesions, apparently inactive; (b) bilateral, symmetrical, apical and subapical distribution indicative of haematogenous origin; (c) cavities, when present, thin walled and with tendency to symmetrical distribution; (d) relative absence of bronchogenic dissemination; (e) evidence of regression or stability in the pulmonary lesion with superimposed haematogenous spread a not uncommon feature.

Review of the chest films of 100 control patients admitted because of pulmonary symptoms and without clinical evidence of extrapulmonary tuberculosis, emphasized the acute exudato-caseous nature of the usual adult pulmonary tuberculosis with its tendency to bronchogenic spread. Eighty-three cases exhibited exudative lesions, 70 of them predominantly so. Although this preponderance of acute exudato-caseous lesions with rapid spread was to be expected in view of the many emergent cases admitted, the pulmonary pathology of this group differed so markedly from that of the group with extrapulmonary tuberculosis as to permit a valid comparison.

A small percentage of the patients without evidence of extrapulmonary tuberculosis exhibited a pulmonary picture similar to that found in the group with extrapulmonary tuberculosis. These few cases demonstrated bilateral symmetrical lesions with tendency to chronic course and absence of bronchogenic spread. In a few instances, cavitation of the thin walled variety with marked tendency to contraction and healing was also noted.

It seems that the dissemination of bacilli, resulting in extrapulmonary lesions and in many cases associated pulmonary pathology with a strong tendency toward benign chronic course, produces some form of immunological response bringing about increased resistance.

THE LYMPHATIC DRAINAGE OF THE PLEURA AS DEMONSTRATED BY THOROTRAST*

J. J. SINGER, M. D.
Los Angeles

FINE particles of thorium dioxide (Thorotrast) injected into the body are taken up by lymphatics, which consequently become radio-opaque. Their distribution, then, as seen in the

x-ray film and confirmed by histological examinations, is similar to that of india ink, carmine and other fine particulate or colloidal substances. It varies, accordingly, with the route of injection and the exact site of the tissues into which the material is placed. An extensive series of such injections performed here on hundreds of animals, including mice, hamsters, guinea pigs, rats and rabbits, have confirmed in most respects the findings of other workers in this regard.

Thorotrast injected intrapleurally appeared in the diaphragmatic sulcus, over the surface of the lung, and in the inter-lobar fissures. X-ray examination showed vertical densities, which did not correspond to normal lymphatics but represented, instead, superimposed boundaries of the various lobes of the lungs. Dissection of the separated lobes of the lungs showed thorotrast fixed on the visceral pleura, in lines and patches, irregularly. On section, part of it was within preformed lymphatics, part in new formed spaces, and part in plaques overlying the pleura. The thorotrast granules were, for the most part, packed in large macrophages or surrounded by them.

There were accumulations of thorotrast in lymph nodes or aggregates of lymphoid tissue on the visceral pleura, as well as in lymph spaces or vessels, but practically none within the parenchymal pulmonary tissues. In the chest wall the thorotrast appeared in horizontal lines between the ribs corresponding to the intercostal lymphatics which drain the parietal pleura. Often two such lines were seen in an interspace. Nodules or patches were seen along these lines, and sometimes the nodules were present when the lines could not be recognized. In addition, following intrapleural injection of thorotrast, many opacities were seen in the mediastinum. These correspond to the substernal, parasternal, hilar and paravertebral lymph nodes, and varied in size, density and number.

The aseptic pleuritis produced in various animal species following the intrapleural injection of talc, thymol, iodide, bismuth formic iodide, iodized oils, gomenol, etc., has been studied extensively in the hope that it might prove of value. It was observed, however, that this procedure is followed by increased spread of tuberculosis from later intrapleural infection. The suggestion that this might be ascribed to blocking of the lymphatics and consequent lack of protective encapsulation was further explored by means of the thorotrast technique.

Accordingly, thorotrast was injected intrapleurally in rabbits which had previously been treated by the intrapleural injection of talc or other substances. X-ray examination showed that the thorotrast following talc showed a tendency to remain at the site of injection and that absorption along the lymph vessels and into the lymph nodes was much less marked than in the controls. Some of this greater localization was probably due to adhesions, obliterative pleuritis which lessened the size of the pleural space into which the thorotrast was deposited, the obliteration of

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Abstract.

From the Laboratories of the Rose Lampert Graff Foundation and Olive View Sanatorium.

Assisted by Lillian Sherman, M. A., Nathan Hiatt, M. D., and Emil Bogen, M. D.

inter-lobar fissures, etc. Part of it may be ascribed, however, to the lessened absorptive capacity of the lymphatics in the thickened pleurae.

Histological examination of the tissues after such injections showed that though many of the lymph vessels and nodes contained talc bearing macrophages, some thorotrast was also present in these structures. Some thorotrast, therefore, was able to pass along the lymphatics, despite apparent filling of the latter by talc. The talc-filled lymphatics had been occupied or distended, but not completely blocked, by the talc. The thorotrast injected after a talc pleuritis had been induced, however, tended to remain in the periphery of the lymph vessels and nodes, rather than to pass toward the center with the talc previously administered.

A similar picture was observed when the thorotrast was injected following the production of tuberculosis by intrapleural injection. Here the parietal lymph nodes and granulations were outlined on the x-ray by a thin layer of thorotrast, giving an interesting delineation of their location and extent. Histological sections showed that the thorotrast, in these cases, also passed through the lymph vessels and around the lymph nodes.

This property of thorotrast of outlining previous pathological lesions in the pleural cavity may be of interest and even of value. The delineation of intrapleural metastatic malignancy was suggested as one possibility, similar to the demonstration of intraabdominal malignancy by thorotrast. The delineation of the character and extent of pleural adhesions and of their pleural lymphatic connections may also be feasible. The possibilities of such work, however, their advantages, disadvantages, technique, indications and contraindications, all remain for future investigations. It is hoped that this demonstration of the manner in which thorotrast may be used in the visualization of pleural lymphatics may aid in stimulating further work in this direction.

SURGICAL ASPECTS OF PLEURAL ADHESIONS*

JOHN C. JONES, M.D.
Los Angeles

IT IS agreed that the effectiveness of pneumothorax is in direct proportion to the completeness of the collapse of the tuberculous lesion. About one-fifth of all attempts at artificial pneumothorax fail and between 40 and 50 per cent of pneumothoraces established are either incomplete, inadequate or ineffective because of isolated adhesions. Complete and concentric collapse and relaxation of the diseased lobe or lung is necessary if effective treatment is to be obtained.

Experience has shown that adhesions preventing perfect collapse may gradually stretch or rup-

ture in a few weeks or months. Should adequate collapse not be accomplished in the first six months the collapse will probably remain inadequate but no definite time can be set. Frequently extensive adhesions show a steady yielding which justifies a continuation of pneumothorax. It is generally agreed that intrapleural pneumonolysis should not be employed until the pneumothorax has been present for from three to six months, but that it is indicated earlier when needed to control severe hemoptysis, pain, or protracted or violent coughing. It should also be used earlier when apparently operable adhesions are holding open cortical cavities surrounded by exudative lesions in order to eradicate the trauma on the diseased portion of the lung during respiration. In cases in which early release of adhesions is demanded but dangers of pneumonolysis are too great, as in acute pleuritis, immediate temporary phrenic paralysis may be used. However, phrenic paralysis, in my opinion, is no substitute for closed pneumonolysis.

The desirability of thoracoplasty over closed intrapleural pneumonolysis is still a discussed question. In cases in which adhesions appear to be inoperable or their division extremely dangerous and difficult and attended with great risk of post-operative complications with small likelihood of resultant adequate collapse, thoracoplasty should be chosen. The majority of surgeons prefer pneumonolysis in cases presenting operable adhesions over pulmonary lesions that will probably respond to subsequent pneumothorax. In some cases, too, thoracoplasty is contraindicated by virtue of contralateral pulmonary disease.

Not all adhesions need be divided. Those producing tension on non-cavernous and exudative lesions if divisible should be operated; also, adhesions on areas previously containing cavity or active lesions. The earliest possible conversion of sputum is of utmost importance to the patient. Such conversion of sputum is a more accurate determination of effective collapse than is roentgenologic evidence.

The only absolute contraindication to intrapleural pneumonolysis is mixed infected tuberculous empyema and a progressive obliterative pleuritis. Active lesions in the contralateral lung provided they are presumably curable with or without collapse therapy are aided by complete collapse of the "bad" lung. Usually there is no indication for collapse therapy on the contralateral lung until complete collapse of the worst lesion has been accomplished. Bilateral collapse is no contraindication provided the vital capacity of the patient is sufficient to withstand the increase in collapse. Serous effusion or even pure tuberculous empyema does not constitute contraindication unless an acute or subacute pleuritis be present. Ordinarily, thoracoplasty is preferable when the pleura is studded with tubercles but pneumonolysis is possible if it can be done without disturbing the tubercles.

The final decision of the operability of adhesions cannot be made except by careful scrutiny

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 11, 1942.

Abstract.
From College of Medical Evangelists, Los Angeles, California.

of the entire field through the thoracoscope. Some adhesions may not be seen on the roentgenogram and apparent adhesions seen on the roentgenogram may prove to be ridges of parietal pleura leading to lung diffusely adherent to the chest wall.

The simple method of Jacobus still remains the most practical and popular technique of pneumonolysis. I personally prefer the simple galvanocautery and two puncture method. The galvanocautery is less expensive than the electro-surgical instrument; it is simple, easy to keep in order and cheaper to repair. Also the degree of heat is simpler to control and it is less painful to the patient when cauterizing close to and in the parietal pleura. The apparatus is also easy to transport from one sanatorium to another. The incidence of pleural effusion and of hemorrhage is no greater although it is easier to control bleeding and oozing with the high frequency coagulation. The two cannula method gives a wider range of vision and greater freedom for work; it also will carry all instruments. The site of puncture is variable. Following a pneumothorax refill a day or two previously, fluoroscopy or roentgenography will usually reveal a free space for the introduction of the first cannula in the fourth, fifth or sixth intercostal space in the midaxilla. Through a one and one-half centimeter incision in the skin and subcutaneous tissues, the trocar, cannula and thoracoscope are introduced, the pleural cavity explored, and the site of introduction of the second cannula determined. If the adhesions are extensive, it is better for both the surgeon and the patient to divide the operation into two or more stages. The skill and patience of the surgeon at all times must be at its optimum and a two-stage operation is less tiring to both surgeon and patient. One of the most important rules of the operation is to know when to stop, both in time and type of adhesions to be divided. Unless the surgeon is sure, after a thoracoscopic examination, that enough adhesions can be divided to control the lesion and to insure satisfactory collapse, he should cauterize none at all.

Thorough knowledge not only of the anatomy of the pleural cavity but also of the pathologic anatomy of pleuropulmonary adhesions is essential to successful pneumonolysis. The condition of the endothoracic fascia is an important criterion.

Postoperative complications: A moderate amount of subcutaneous empyema around the areas of introduction of the cannulas may be present but usually disappears within three days. In one-third of the cases a slight to moderate transient serous or sanguiniferous effusion will appear which disappears in two to four weeks. Aspiration of residual fluid and blood clot before withdrawing the cannulas will reduce materially the incidence of postoperative effusion and fever.

The incidence of tuberculous empyema is less than would follow lack of control of lesions by incomplete pneumothorax. Mixed infected tuberculous empyema is a serious complication. The

etiology is usually a bronchopleural or pleuro-cutaneous fistula rather than an infection due to "break in technique." Hemorrhage is not a frequent complication. Oozing from puncture wounds or bleeding from a branch of the intercostal vessels during dissection is easily controlled. Hemorrhage necessitating thoracotomy is rare. A pneumothorax may be lost by leakage of air through the cannula track or as a result of an obliterative pleuritis. Air replacement at frequent intervals is indicated for the former. Obliterative pleuritis is not common, but its incidence is definitely higher than in unoperated pneumothoraces.

Open pneumonolysis is a major procedure which carries with it potentially serious dangers and should not be considered a substitute for the closed method. It should be reserved for that small group of cases in which closed pneumonolysis and phrenic nerve paralysis have failed and in which thoracoplasty is contraindicated.

Results cannot be based on the success or failure to divide adhesions but must be evaluated by extensive workup and complete follow-up data of each case. Such complete data was obtained in all of the 38 cases which constituted my series at the Barlow Sanatorium during the years 1936 and 1939 inclusive. Although the series is too small to allow definite conclusion to be drawn, we believe the results are worth reporting.

In this series of cases, when sputum is referred to as negative, it includes cultures and guinea pig inoculations of both the sputum and fasting gastric contents unless otherwise specified. In referring to conversion of sputum, it is specifically implied that the sputum and the gastric contents are converted to "negative for tubercle bacilli" by flotation, culture and guinea pig inoculation, the date of conversion being estimated to be the date of first negative cultures after the last date of finding of tubercle bacilli by any method.

TABLE I

Results of 38 thorascopies at Barlow Sanatorium
1936-1939 (inclusive)

Apparently Cured	Arrested	Appar- ently Arrested	Quies- cent	Improved	Dead
13 (34.2%)	*21 (55.2%)	1 (2.6%)	1 (2.6%)	1 (2.6%)	*1 (2.6%)

* Two of the 38 cases (one arrested and one dead) had thoracoscopy only without ill effect, the remaining 36 cases had all or the major portion of adhesions severed.

The 13 apparently cured patients are well, and are leading normal lives; their sputums and gastric contents are negative, there is no evidence of activity by x-rays and their lungs are all expanded, including two bilateral pneumothoraces. In one of the bilateral cases both lungs were collapsed for four years; in the other, for four and six years. In nine of the unilateral cases pneumothorax was carried for their full term of collapse before re-expansion was allowed. One developed an obliterative pleuritis nineteen months after division of adhesions and had a three-stage thoracoplasty without event. In the remaining unilateral case, the patient developed acute staphylococcus

aureus empyema two-and-one-half months after pneumonolysis, was tube-drained, given a phrenic paralysis; on bed rest his lower lobe cavernous lesion healed, the lung re-expanded and the empyema healed solidly.

In the 21 arrested cases, the patients are still carrying pneumothorax, although several are about ready for re-expansion. Among this group are four bilateral pneumothoraces. They are all leading normal lives; they have been negative to all sputum and gastric examinations for over a year to five years, and their x-rays show arrested lesions, without apparent activity. One of these patients had no adhesions severed, but pneumothorax was pushed.

In the one apparently arrested case, the patient has been negative to all tests for 10 months, and negative to all tests except gastric guinea pig inoculations for two years previous to that; his x-rays show no active lesion, and he has been on one or two hours exercise twice a day for many months.

In the one quiescent case, the patient is ambulatory, has no activity by roentgenograms, has an excellent collapse except for one remaining inoperable adhesion close to the mediastinum, and has been positive only to guinea pig inoculation for a year and half.

In the one case improved, the patient had all fourteen adhesions divided at operation, and has an excellent collapse except at the base. She looks and feels well, does a moderate amount of housework, but her cultures are still intermittently positive.

The only death in the series was that of a patient re-admitted with a six-and-one-half-year old pneumothorax for thoracoplasty. It was found no adhesions were suitable for division so nothing was done. She had far-advanced bilateral tuberculosis from which she died in another sanatorium three-and-one-half years later. The thoracoscopy had no ill effects.

The majority (27 cases) had adhesions divided within the first twelve months of pneumothorax and of these 11 are apparently cured, 14 are arrested, 1 is improved and 1, quiescent.

In 36 of the 38 cases, all or the major portion of adhesions were divided and in two cases only thoracoscopy was performed without event. Of these 36 cases, all adhesions were divided in 18 cases (50 per cent) and the major portion of the adhesions were cauterized in 18 cases (50 per cent). We advocate early (within six months) pneumonolysis. This small series fails to bear out its advantages, but a larger series might possibly do so. It is noteworthy that of the entire series of thoracoscopies (38) only two were wholly inoperable.

TIME OF SPUTUM CONVERSION

There were 34 patients in whom adhesions were divided, who converted their sputum, became apparently cured (13 cases), arrested (20 cases), or apparently arrested (one case). Twenty-one of these patients had unilateral disease and

converted their sputum in an average of five and one-half months after pneumonolysis, with the exception of one patient with ipsilateral tracheo-bronchial tuberculosis who took four years for permanent conversion, in spite of complete collapse of the lung after division of all ten adhesions. Seven of the 21 had an immediate conversion of sputum following pneumonolysis. In the remaining 12 converted cases bilateral active disease was present at the time of pneumonolysis, and in six of them bilateral pneumothorax was required, although none of them had bilateral pneumonolyses; this group required an average of 23 months to become negative. There were, of course, no immediate conversions of sputum in this group. It might be added that in the entire series the sputum was positive at the time pneumonolysis was performed. In this group, also, there was no notable difference in the conversion time of those operated within six months and one year after pneumothorax was instituted and those operated over a year after the pneumothorax was begun.

POSTOPERATIVE COMPLICATIONS OF 38 THORACOSCOPIES

One patient developed obliterative pleuritis and pneumothorax was lost; thoracoplasty was substituted 19 months after pneumonolysis. He never has had a positive sputum since his surgery and is apparently cured.

One patient developed staphylococcus aureus empyema suddenly 10 weeks after pneumonolysis and was tube-drained. He already had a phrenic paralysis which has left the diaphragm in a high fixed position. On bed rest the lung re-expanded, the empyema healed solidly, a cavity in the left lower lobe closed, and he has been apparently cured for almost three years.

Slight moderate and usually localized subcutaneous emphysema is found in the majority of cases if it is looked for. In none was it large in amount or in any way troublesome to the patient.

There was no hemorrhage at the time of surgery or any evidence of post-operative bleeding in any of the cases.

Dyspnea, bronchopleural fistula, pleurocutaneous sinus or nerve injury did not occur.

Twenty of the 38 patients (52.6 per cent) developed slight transient effusion following thoracoplasty and pneumonolysis, all of which absorbed in from eight to twelve weeks without aspiration. Three patients (8 per cent) had a seropurulent effusion (positive for tubercle bacilli) at the time of pneumonolysis; in one, the effusion disappeared following operation; in two, it has been persistent but in such small quantities as to require aspiration rarely.

Three patients (8 per cent) developed tuberculous effusion many months following pneumonolysis and required aspiration at intervals of several months, but in no case has it been alarmingly rapid or in large amounts and there has

been no interference with the carrying on of the pneumothorax.

SUMMARY

The importance of converting an inadequate pneumothorax into an effective complete collapse by severing adhesions even in the so-called "symptom free" patient is stressed; and the importance of frequently repeated careful and extensive sputum examinations to determine the date of a lesion's arrest is discussed, as is the evaluation of roentgenographic series before and after collapse therapy has been instituted. Results of closed intrapleural pneumonolysis are given along with operative and post-operative complications.

ARTIFICIAL PNEUMOTHORAX FOR TUBERCULOUS PNEUMONIAS *

CLIFFORD V. MASON, M. D.

San Leandro

WHILE all tuberculous lesions of the lung are initially of pneumonic character, the term tuberculous pneumonia predicates an acute lesion more or less sharply localized within the lung or its lobar subdivisions. In essence it represents a caseous or gelatinous consolidation, the result of a bronchogenic dissemination from pre-existent parenchymal or bronchial lesions. For this reason the distribution is circumscribed rather than widespread in the respiratory parenchyma.

Pathologically, tuberculous pneumonia partakes of the nature of all the acute ulcerative forms of pulmonary tuberculosis, but with an accelerated tempo in its pathogenesis, that has earned for it the synonyms "galloping consumption" and "phthisis florida." Progressive and regressive phases, and resolution with fibrosis and calcification exist simultaneously. Clinically, the patient is, as a rule, acutely sick. Prostration and the depletion of bodily reserves bespeak an unfavorable prognosis.

The plan of the therapeutic campaign should be the product of the integration of certain values and considerations, many of which are imponderable.

The clinical condition of the patient as it reflects his response to the new invasion, the degree of prostration and physical depletion may argue for a *noli me tangere* attitude. Extremes of reaction, clinically speaking, reflect not so much the extent of the lesion as the response to lesion. In fulminant cases, therefore, the judgment as to where and how to interfere should lean to the side of conservatism. A preliminary "cooling off" period under conditions of basal rest and supportive measures has much in its favor.

Provided the intensity of the new infection lies within tolerable limits for the individual, thoracic lymphatics play a vital rôle in the isolation of invading organisms from the new field of spread. The integrity of this defense, in its intact state, particularly in younger individuals where the lymph and vascular architecture is less apt to be modified by precedent infection, and/or the attacks of environment, has been seen to effect a rescue in pneumonic phthisis, unaided by measures other than rest.

In not a few tuberculous pneumonias there is a predominance of either the productive or exudative phase. When a solid, caseous lobe is encountered, obviously an artificial pneumothorax cannot achieve a collapse. The detelektasis of the exudative type, while it may likewise caseate, commonly undergoes spontaneous resolution as the productive phase begins to wane.

Epituberculosis, especially when extensive, lends itself poorly to air collapse, since it represents an airless state of the parenchyma engendered by an interstitial compressive edema. Precipitate induction of artificial pneumothorax as it is applied to minimal or moderately advanced discrete lesions, tends to yield an organized, cornified and non-expansile lung. Associated as it is with profound toxic manifestations, attempted collapse in lesions of this type affects only the circumjacent normal tissue, with subsequent increased anoxia and misery to the patient.

A supplemental measure that has proved of value in the "cooling off" period has been the induction of artificial pneumoperitoneum, particularly where the lesion is basal, or at least in the lower half of the lung. This therapeutic measure permits a revokable procedure which provides lung relaxation without the profound modification of intrathoracic pressure relationships that obtain in artificial pneumothorax as ordinarily administered. The augmented lung rest so obtained during the "cooling off" period advances the arrival of a break in the septic swing of the fever. The criterion for intrathoracic air collapse of the affected lung had best be defined as the period when clearing of the lesion is roentgenologically evident. No arbitrary period can be set, but the lull in the storm may not transpire under three months from the onset of the explosive phase.

Where pneumonic processes occupy the upper half of a lung field, the choice of conservative interference may be in the direction of a controlled or fractional artificial pneumothorax. In contradistinction to the conversion pneumothorax, where cavity closure and sputum conversion is the goal, fractional artificial pneumothorax aims at a degree of lung relaxation compatible with the least interference with uninvolved respiratory tissue and lymph flow, plus a moderate circulatory hyperemia. Frequent small refills tend to maintain a just appreciable pneumothorax space under fluoroscopic control. Excessive adhesion formation is obviated. In the event of favorable regressive changes, a conversion collapse becomes feasible.

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Abstract, panel discussion.

From Fairmont Hospital, San Leandro, California.

In instances of double or bilateral tuberculous pneumonia, where the prognosis is usually unhappy, pneumoperitoneum alone would seem to be the operation of choice, irrespective of localization of lesions.

It is unfortunate that our sanatorium classifications and disease indices show a lack of precision in the exact classification of the various types of lesions falling under the heading of tuberculous pneumonia. Without a definite breakdown into types of lesions, it is most difficult to evaluate selectively. The seeker after information is defeated beforehand by the amount of work involved in culling a large enough group of selected cases over a given period of time.

SUMMARY

- 1. The prognosis in tuberculous pneumonia is grave. In bilateral cases especially so.
- 2. A preliminary "cooling off" period of basal rest, supplemented by pneumoperitoneum is desirable.
- 3. The length of the period of conservative therapy should be determined both by the clinical picture, and by frequent serial roentgen examinations.
- 4. Conversion pneumothorax is contraindicated for the immediate treatment of the extensively involved and fulminant case.
- 5. Fractional artificial pneumothorax may be advantageously employed in unilateral apical involvement.
- 6. Bilateral tuberculous pneumonias demand pneumoperitoneum alone, if any form of collapse therapy is considered applicable.

PLEURAL EFFUSIONS COMPLICATING PNEUMOTHORAX*

JOSEPH GOORWITCH, M. D.
Olive View

It is reported that more than half of all pleural effusions complicating induced pneumothorax arise during the first six months of pneumo-

thorax therapy, that from 15 to 25 per cent of all serous effusions eventually become purulent, and that from 40 to 100 per cent of purulent effusions begin as serous effusions. The findings in a series of 41 patients with pleural effusions support these figures.

The series consisted of one group of 21 patients, in whom effusion developed; and one group of 20 patients, in whom the effusion had been noted on an average of five months before coming on my wards. Sixty per cent of all effusions developed within the first six months of pneumothorax therapy, the average interval between induction of pneumothorax and the onset of effusion for the entire series being exactly six months.

Prior to the onset of effusion, the great majority of patients had far-advanced bilateral pulmonary disease and positive sputum. All but one had mechanically unsatisfactory collapse and patent cavitation and one-third also had contralateral cavitation. This 97 per cent incidence of mechanically unsatisfactory collapse is suggestive of etiological connection (Table I).

A more immediate and direct cause of the effusion was obvious only in a small fraction of the series. The onset was febrile in 26 of the 32 cases; the average maximum temperature was 102 degrees and the average duration of fever two and one-half weeks. In all patients in whom the effusion became purulent, and the type of onset of effusion was known, it was found to be febrile.

The study demonstrated the universally serious onset of effusion and the subsequent conversion to purulent fluid in 33 per cent of patients. In about 75 per cent of patients, tubercle bacilli were found in the effusion. In patients in whom the onset of effusion was febrile, the incidence of fluid positive for tubercle bacilli was three times as great as in patients in whom the onset was afebrile. Pyogenic cultures were negative throughout (Table II).

To prevent the various complications of pleural effusions, all patients were treated by frequent

TABLE I
Status Prior to Onset of Effusion

Group and No. of Pts.	N. T. A. Classification		Distribution of Disease		Cavitation		Sputum		Type of Pneumothorax		Average Duration of Pneumo. (months)
	MA	FA	Unilateral	Bilateral	Collapsed Lung	Uncollapsed Lung	+	-	Mechanically		
									Satisfactory	Unsatisfactory	
I 21	6	15	10	11	21	9	13	8	1	20	8
II 20	2	18	7	13	20	4	18	2	0	20	4
I and II 41	8	33	17	24	41	13	31	10	1	40	6

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From Olive View Sanatorium.

aspirations and most of those with purulent fluid also by intrapleural instillation of neoprontosil (Table III).

End-results regarding pneumothorax and effu-

sion at the time of death, or at discharge from Olive View Sanatorium and in March, 1942, for those still at Olive View, reveal pneumothorax was maintained in about one-half of the patients, the great majority of whom achieved cavity closure and sputum conversion in spite of the fact that in three-fourths of the cases collapse was

In those in whom pneumothorax was maintained even though the amount of collapse at termination of treatment was practically the same as prior to onset of effusion, the average size of refills and their frequency decreased and the average intrapleural pressures at the end of refills rose to become positive. This suggests that,

TABLE II
Pleural Effusions
(all negative for pyogens on culture)

Group and No. of Pts.	Type of Effusion at Onset		Subsequent Conversion to Purulent Fluid	Tubercle Bacilli							
				+	-	Number of Specimens Examined; Methods and Results					
						Smear		Culture		G. Pig	
	Serous	Purulent				+	-	+	-	+	-
I 21	21	0	2	14	7	3	53	24	27	6	10
II 20	18	?	11	16	4	23	54	27	15	4	1
I and II 41	39	..	13	30	11	26	107	51	42	10	11

TABLE III
Treatment of Pleural Effusions

Group and No. of Pts.	Average Interval between Onset of Effusion and Aspiration (weeks)	Pneumothorax		Average					Intrapleural Medication	
				Number of Aspir.	Number of Mos. of Aspir.	Frequency of Aspir. (days)	Total Volume Aspirated (c.c.)	Volume per Aspiration (c.c.)		
		M	Not M						S	P
I 21	2	20	1	8	2	10	1000	125	0	A-1 M-1
II 20	6 (for 10 Pts.)	10	10	23	6	9	2000	90	0	A-1 N-10
I and II 41	3 (for 31 Pts.)	30	11	15	4	10	1500	100	0	A-2 M-1 N-10

"M"—maintained; "S"—serous; "P"—purulent; "A"—alcohol 95%.
"M"—merthiolate solution, 1:5000; "N"—Neoprontosil solution, 2½-5%.

still mechanically unsatisfactory. Fluid persisted in only three out of the total of 41 patients and then only in small amounts. The average number of months since final aspiration was 14 for the entire series (Table IV).

at least in this series, positive intrapleural pressure is a result and not a cause of the pleural effusion.

In comparing the clinical end-results with the pre-effusion status, we observe, (1) cavity clos-

TABLE IV
End-Results of Pneumothorax and Effusion
(at time of death in, or discharge from Olive View Sanatorium and March 1942 for those still in Olive View Sanatorium)

Group and No. of Pts	Fate of Pneumothorax			Type of Pneumothorax Maintained		Fate of Effusion		Average Number of Months since Last Aspiration
				Mechanically				
	Maintained	Discontinued	Lost	Satisfactory	Unsatisfactory	+	-	
	I 21	13	4	4	4	9	1	
II 20	7	13	0	1	6	2	18	
I and II 41	20	17	4	5	15	3	38	

TABLE V
Clinical End-Results
(at time of death in, or discharge from Olive View Sanatorium and March 1942 for those still in Olive View Sanatorium)

Group and No. of Pts.	N. T. A. Classification		Distribution of Disease		Cavitation		Sputum		Clinical Status (N. T. A.)					
	MA	FA	Unilateral	Bilateral	Collapsed Lung	Uncollapsed Lung	+	-	D	U	I	Q	AA	A
I 21	6 (M-1)	14	8	13	5	3	6	15	2	3	2	3	9	2
II 20	3	17	9	11	2	1	4	16	0	1	1	6	10	2
I and II 41	10	31	17	24	7	4	10	31	2	4	3	9	19	4

ure and sputum conversion in over three-fourths of the cases and (2) arrest or apparent arrest of disease in more than half. Of the 23 arrested or apparently arrested cases, three had a homolateral and one contralateral thoracoplasty; another five thoracoplasty patients were operated on too recently to be rated better than quiescent. Pulmonary cavitation and not empyema was the indication for thoracoplasty in all nine patients but an additional thoracoplasty stage to obliterate the empyema pocket was done in two cases and was successful in only one (Table V).

In reducing the incidence of tuberculous empyema in artificial pneumothorax, two procedures are suggested: (1) discontinuance of ineffective pneumothoraces as soon as the ineffectiveness of complementary collapse measures has been demonstrated; and (2) treatment of serous effusions of 100 cc. or more by frequent aspirations as they must be regarded as potential empyemas.

15 cases; in only four did empyema develop. Spontaneous pneumothorax occurred in five patients. Adhesions were noted in 33 cases. In four cases pneumonolysis was performed, in two of whom the pneumothorax was considered effective; in another, fluid followed and the space was converted into an oleothorax. In 20 cases the pneumothorax pocket was supplemented by a phrenic crush.

The results of treatment in cases in which pneumothorax was established, as compared with the group in which it failed, were as follows:

	Pneumothorax Pocket		Pleural Synthesis	
Arrested	6	10%	4	15%
Improved	11	18%	5	18%
Unimproved ..	27	43%	8	30%
Dead	18	29%	10	37%
Total	62		27	

SUMMARY AND CONCLUSIONS

The results show little difference between the two groups. This small series suggests: Pneumothorax effective in only 16 per cent of these patients; obliterated pleural space prevented establishment of pneumothorax in 30 per cent of these older patients; complications to pneumothorax here were not serious; other forms of collapse such as phrenic crush and/or pneumoperitoneum were as effective as pneumothorax; careful consideration of the physiologic status of the patients in the older age group should be given before attempting to establish pneumothorax.

PNEUMOTHORAX IN THE TREATMENT OF ACUTE MINIMAL TUBERCULOSIS *

EDWIN G. KIRBY, M.D.
San Diego

IN ITS most characteristic connotation, the term acute minimal tuberculosis implies a recent, or relatively recent small area of pulmonary infiltration without cavitation. This lesion is most

PNEUMOTHORAX IN THE OLDER AGE GROUP *

J. DWIGHT DAVIS, M.D.
Olive View

IN a group of 89 patients, varying in age from 43 to 65, pneumothorax was attempted. Cases were selected on the usual criteria for artificial pneumothorax, primarily unilateral state of the disease, presence of cavity and/or positive sputum. Forty of these cases were in the 5th decade of life, 41 in the 6th decade, and eight in the 7th decade. All but six were far advanced, and all but 10 presented cavities.

A pneumothorax pocket was established in 62 individuals, including two bilateral cases. Attempt at pneumothorax was unsuccessful in 27 cases due to adhesions; in 34 individuals the pneumothorax was abandoned in less than one year as ineffectual. Fluid was aspirated in only

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From Olive View Sanatorium, Olive View, California.

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.
Abstract, panel discussion.
From Vauclain Home, San Diego.

often found beneath the clavicle or in the first or second anterior interspace and is described by the roentgenologist as "soft."

Typically, we might expect the patient to be a healthy-appearing adolescent or young adult who has been in direct contact with a case of active tuberculosis. Cough, sputum, hemotysis or other classical symptoms have usually not appeared. Constitutional symptoms are absent or are limited to malaise, anorexia or slight weight loss. Careful physical examination of the chest is usually negative. The Mantoux test is positive, while the sputum or gastric contents may or may not be positive.

Although the foregoing might be described as "typical," each individual case represents a problem for the physician to solve, not only on the basis of his experience in the usual methods of treatment, but also on his knowledge of the social background, economic status and psychological make-up of his patient. Such important considerations as age, sex, race, occupation, co-existing diseases and length of exposure to tuberculosis must be carefully weighed.

To obtain this information, a period of observation at basal conditions, i.e., absolute bed rest is essential. Whenever possible, this period should be spent in a hospital for the tuberculous, away from the distracting influences of the family. This period, as pointed out by Hegner, should be measured in terms of weeks rather than months.

Occasionally, a lesion which roentgenologically seems entirely typical, will clear in the space of two or three weeks, indicating a mistaken diagnosis.

The acute early infiltrate is always an unstable lesion, it soon regresses or progresses. Absorption or fibrosis may follow; or there may be rapid or slow progression with caseation, liquefaction and excavation.

The indications for pneumothorax are numerous, but in my opinion, the following are the most important. The production of positive sputum indicates that tissue necrosis has already occurred, and for this reason, these cases should be given pneumothorax promptly. Likewise, lesions with x-ray evidence of beginning breakdown should be collapsed immediately.

If the lesion continues to progress on bed rest, immediate collapse is indicated, even though the sputum remains negative. In addition to serial x-rays; careful pulse, temperature and respiration records, sedimentation index and differential white count are valuable indices of the patient's course under therapy.

There are supplementary, more personal indications for pneumothorax which have not been mentioned so prominently in the literature. The family wage-earner may prefer immediate collapse and the attendant shorter period of hospitalization and disability to the more conservative, if equally effective period of absolute bed rest.

Likewise, the non-coöperative, the unintelligent, or the trouble-making patient may be much

better controlled by pneumothorax. In our experience, the most difficult patient to handle in the sanatorium is the apparently healthy individual with no symptoms. He finds it boring to maintain himself at bed rest and all too frequently leaves the hospital against medical advice. We have many times started pneumothorax because we have concluded that it was the only way to control both the patient and his lesion.

The adolescent girl with minimal tuberculosis requires especially close observation, and if there is any question as to lack of satisfactory progress, pneumothorax should be done.

Turner and Collins have listed as advantages of pneumothorax in these cases, the shorter period of hospitalization and disability, the shorter conversion time in case the sputum is positive and the fact that in their opinion, the end results are better. It should also be emphasized that the doctor sees his pneumothorax cases oftener and any change will be detected sooner. He is likewise in a better position to regulate their social and vocational activities.

The chief arguments against pneumothorax are: the inconvenience to the patient, the necessity for the long and expensive period of treatment and, most important, the danger of complications. While the latter are rare in minimal cases, pleural effusions, empyema, spontaneous pneumothorax, bronchopleural fistula and non-expansile lung do occur.

SUMMARY

Beginning tissue necrosis, positive sputum and lesions which are progressive on absolute bed rest, are, in my opinion, absolute indications for pneumothorax.

There is no such thing as a "routine" treatment for minimal tuberculosis. It is equally absurd to say that every case should receive pneumothorax as it is to say that collapse should never be used until the disease becomes moderately or far advanced.

Once a small area of pulmonary infiltration has been definitely diagnosed as being tuberculous, the patient should be treated for *tuberculosis*, and not for a "spot on the lung." There are too many patients with "spots on the lung" who only discover that they have tuberculosis when referred to a specialist after their disease has progressed beyond the minimal stage.

If the "early diagnosis" campaign is justified as it most assuredly is, then an "early and adequate treatment" campaign is likewise indicated.

The adequate treatment of acute minimal tuberculosis does not consist in merely telling the patient to "take it easy." It demands a period of absolute inactivity supplemented by pneumothorax or other collapse procedures as deemed advisable by the attending physician.

It is good business to spend money to wipe out tuberculosis. It would be far cheaper in the end than to go on bearing the terrific cost of caring for the tuberculous.

SILENT SPONTANEOUS PNEUMOTHORAX*

A. E. T. ROGERS, M. D.
Olive View

TYPICAL diagnostic symptoms and signs of spontaneous pneumothorax are briefly enumerated; conditions in the chest which tend to mask these signs or cause confusing clinical pictures resembling extra-thoracic complications are mentioned.

Three illustrative cases are presented; a case of spontaneous pneumothorax without symptoms, recognized only at autopsy; one in which physical findings suggest intra-cranial pathology, with no abnormal signs found on examination of the chest; and a case with symptoms suggesting an acute abdominal episode, but with physical signs diagnostic of spontaneous pneumothorax.

It is emphasized that the occurrence of any acute complication in the course of pulmonary tuberculosis or of pneumothorax therapy should arouse suspicion of spontaneous pneumothorax; physical signs may be misleading, and fluoroscopy, radiography and diagnostic aspiration should be resorted to in an effort to establish or rule out the existence of a pneumothorax space.

Slide No. 3		Slide No. 4	
Operations	Oleothoraces	Complications	Total
Total—47	Total—20	Dissection of space with oil	1
Tolerant	18	Broncho pleural fistula	1
Intolerant	2	Air embolus transitory	1
Frequently a small amount of clear fluid forms during the conversion but this practically always disappears with the completion of the oleothorax.		Pyogenic infection	2
		Hemorrhage into space P. O.	3
		Extrapleural cutaneous fistula	1

Slide No. 5		Slide No. 6	
Sputum		Immediate Post-operative Care	
Sputum positive in all cases prior to surgery		Aspiration:	
Total Cases—43		First	48 hrs. P.O.
Negative sputum	38	Second	96 hrs. P.O.
Positive sputum	5	Removal of all sanguinous fluid available. Replace one-half amount of air and then check pressure and adjust to positive 10 cm. water.	
Two of the five positive cases are recently post-operative.			

Slide No. 7							
Present Status							
No. of Pts.	'38	'39	'40	'41	'42	Total	%
Working	7	8	7	2		24	56
Rehab.		3	2			5	12
Conval.	1	1	3	2	2	9	21
Active	1		1	2		4	9
Dead *		1				1	2

* Death in one case due to abdominal pathology.

Slide No. 8
This slide showed a sketch of patient lying on side, shoulders on one table and hips on another, showing aspiration from beneath patient, demonstrating two fluid levels of varying densities within extrapleural pocket.

EXTRAPLEURAL PNEUMOTHORAX**

ELLIOTT P. SMART, M. D.
Murphys

IN view of the interest in the reports of last year, we are taking this opportunity to bring our report up to date. Our enthusiasm for the procedure in properly selected cases continues unabated. Lesions collapsed have been uniformly controlled. Those having persisting positive sputum have invariably had bilateral lesions.

We feel that oleothorax represents a very satisfactory method of conversion but it must be carefully supervised. It has been our experience that the symptoms encountered when the pressure in the space is too great or too little are the same, i.e., a feeling of tightness. The pressure can only be determined by actually checking it with a needle and adjusting it.

The report on the cases, illustrated by lantern slides show in the following tables:

Slide No. 1		Slide No. 2	
Operations	Patients	Operations	Fluid
Total—47	Total—43	Total—47	Total—13
1938	10	Clear	8
1939	15	Purulent	5
1940	13	Transiently purulent...	2
1941	7		
1942	2		

* Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

** Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.
Abstract, panel discussion.
From Bret Harte Sanatorium, Murphys, California.
Assisted by G. W. Prince, M. D., Stockton, California.

PROGRESSIVE PRIMARY TUBERCULOSIS *

JESSE D. COOK, M. D.
Olive View

A PULMONARY primary complex comprises the parenchymal site first infected together with the lymphatic glands, usually hilar, enlarged from draining it. When the primary complex is fully formed, the further course usually is to retrogress. In a test series taken consecutively, progressing cases comprised less than one per cent. Other instances of primary progressive tuberculosis were not so diagnosed on admission, but were recognized on later review.

According to Auerbach, usually the primary focus and the hilar glands enlarge; though in about one-fourth of the cases, only the latter. If there is erosion, whether from parenchymal focus or hilar glands, resulting in canalicular spreads, the foci caused are relatively large and are distributed according to chance anatomic connection. Lympho-haematogenous spread, a very frequent occurrence, results in smaller foci, widely distributed; aside from the lungs and meninges, this distribution occurs in the spleen, kidneys, adrenals, and liver.

Causes given for progression in primary tuberculosis are: early and repeated massive infection; concurrent disease of a type inhibiting allergy, (e.g. measles); race, (e.g. negroes); bad economic conditions and poor hygiene.

The unqualified statement is made that there are but two sure ways to diagnose progressive

* Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

primary tuberculosis—(1) post-mortem, where by the microscope and absence of calcification the lesions are proved throughout to be of the same age; and (2) by a series of skin tests and chest films showing the same result.

A typical case: Mexican girl, seventeen years old, had an attack of "flu" in March, 1936; positive sputum in May, 1936; entered Olive View, June, 1936, showing tuberculous involvement of the left upper lung field and hilar enlargement; slight fever on admission; within seven months increased to septic type and so continued until just before death. Serial films showed gradual enlargement of left paratracheal and bronchial pulmonary masses and extension of parenchymal density in the left upper lobe, but no cavitation. Cervical lymph nodes were enlarged and given x-ray treatment without effect. A phrenic crush and attempt at pneumothorax were of no avail. Following gastro-intestinal symptoms and downhill course, patient died in July, 1937, less than eighteen months after reported onset.

Autopsy showed progressive primary type tuberculous lesions of the left lung, tuberculosis of tonsils and intestines, massive tuberculous adenitis of the lymph nodes draining all these structures, and scattered tubercle in the liver and spleen.

A STUDY OF SANATORIUM DISCHARGE STANDARDS FOR TUBERCULOUS PATIENTS*

INA GOURLEY, M. D.
Livermore

IN the course of treating the tuberculous patient, many questions arise. Many questions as yet have no satisfactory answer. One of these concerns the proper time for discharging the patient from the sanatorium. In an attempt to throw some light on the problem two things have been done. First, questionnaires have been sent to sanatoria asking about their discharge standards; second, our own standards have been checked by means of gastric lavage on a small group of discharged patients.

Thirty questionnaires were sent out. Of these, 21 were returned with sufficient answers to be of help.

The first group of questions has to do with the treatment of primary pleurisy with effusion. The questions are: How long are these patients kept in the sanatorium? How long are they kept on complete bed rest?

REPLIES TO QUESTIONNAIRES

The majority of the institutions are treating primary pleurisy with effusion intensively. One of the sanatoria does not admit uncomplicated

effusion cases because of heavy demand on beds. Fifteen, or 75 per cent, give a total stay of six or more months. Five, or 25 per cent, give a shorter stay in the sanatoria, or determine the length of stay on circumstances of the individual case. Thirteen, or 65 per cent, keep them on bed rest three to six months. Seven, or 35 per cent, keep them in bed approximately two months, or until fluid clears.

TABLE I

Duration of Sanatorium care of primary pleurisy with effusion cases.

	Total Sanatorium Stay		Complete Bed Rest	
	6 months or more	Less than 6 months	3 to 6 months	2 months or until fluid clears
20 Sanatoria	15 or 75%	5 or 25%	13 or 65%	7 or 35%

The second group of questions refers to the length of sanatorium care of tuberculous patients after parenchymal lesions appear stationary on x-ray, all cavities closed and sputum is negative. Six of the physicians found the problems of their patients so varied that they were unable to answer these questions on length of stay. Fifteen of these 21 gave approximate lengths of stay.

The question: How long are patients treated by bed rest without collapse therapy, kept in these sanatoria after x-ray shows cavities are closed, lesions stationary and sputum negative? Four of these 15 sanatoria, or 26 per cent, keep these rest-therapy patients one to six months, and eleven, or 74 per cent, keep them six to twelve months.

TABLE II

Lengths of stay of bed rest patients after x-ray lesions stationary and sputum negative

	1 to 6 months	6 to 12 months
15 Sanatoria	4 or 26%	11 or 74%

The sanatoria reporting the shortest length of stay after negative sputum are the sanatoria with the most rigid interpretations of negative sputum.

Patients with unilateral tuberculosis treated by bed rest plus pneumothorax are kept one to six months in 11, or 73 per cent, of the 15 sanatoria studied; and six or more months in four, or 27 per cent of the sanatoria, after cavities are closed and sputum is negative.

Patients with bilateral pulmonary tuberculosis are kept about the same length of time after sputum conversion, regardless whether they are treated by unilateral or bilateral pneumothorax. Nine, or 60 per cent, of the sanatoria keep them one to six months; and six, or 40 per cent, keep them six or more months.

Patients treated by pneumoperitoneum or pneumoperitoneum plus phrenic crush are given a slightly longer stay than those with bilateral disease treated by pneumothorax. Two sanatoria studied do not use pneumoperitoneum.

Patients treated by thoracoplasty are kept three to six months after the last stage of thoracoplasty by six, or 40 per cent, of the sanatoria, and more than six months by nine, or 60 per cent.

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.
Digest.
From Arroyo Del Valle Sanatorium, Livermore, California.

TABLE III

Length of stay of collapse therapy cases in sanatoria after x-ray lesions stationary, cavities closed and sputum negative. 15 sanatoria report:

Unilateral Disease with Pneumothorax		Bilateral Disease Unilateral or Bilateral Pneumothorax		Thoracoplasty	
1 to 6 months	6 months or more	1 to 6 months	6 months or more	3 to 6 months	6 or more months
11 or 75%	4 or 27%	9 or 60%	6 or 40%	6 or 40%	9 or 60%

All of the 21 questionnaires give answers to the third group of questions on interpretation of negative sputum. There are 16 different answers. Five are in favor of three-day cultures. The 16 different answers vary from culture of a single morning specimen to an exhaustive study of each patient's sputum by direct smear, flotation, culture and repeated guinea pig inoculation of gastric contents. If the patient's sputum is negative by all these tests, an effort is then made to collect all of his sputum for 30 days and the sediment is injected into a guinea pig. Needless to say, this is a very wide difference in standards. Six, or 28 per cent, of the 21 sanatoria make gastric lavage with culture or guinea pig inoculation a discharge routine. Uniform discharge standards do not exist among these sanatoria because of the lack of agreement on when sputum has become negative.

Most of the sanatoria, however, meet the minimal laboratory standards as published in the report of the Committee on Standard Laboratory Procedure of the American Trudeau Society. This report appeared in the American Review of Tuberculosis, January, 1942, and is as follows: "For classification for discharge and for prognosis, as a negative sputum case, but not necessarily arrested: Three successive 24-hour concentrations at intervals of not more than a week . . . where facilities permit, a culture or animal inoculation is recommended with concentration."

The second portion of this paper has to do with an evaluation of our discharge standards. They are as follows: Primary pleurisy with effusion cases are kept on complete bed rest six months and may be given a work-up of a month or sent home for the work-up period, depending on circumstances. Patients with parenchymal lesions are kept in the sanatorium approximately three months after lesions are stationary, cavities closed, and sputum negative, regardless whether they have been treated by bed-rest, unilateral or bilateral pneumothorax or pneumoperitoneum. Patients treated by thoracoplasty are kept six months after surgery is completed. Our interpretation of a negative sputum is a one-week concentration and microscopic examination. Gastric lavage is not a discharge requirement.

With these standards in mind, 44 tuberculous patients were studied at the time of discharge by gastric lavage and guinea pig inoculations. All of these patients had some form of collapse therapy. There was almost an equal number of men and women. The men ranged in age from 17 to 49 years. The women ranged from 13 to 54 years. Twenty-nine of the 44 were of the

white race; the remaining 15 were Negroes, Mexicans and Orientals. Twenty-seven of these 44 cases received unilateral or bilateral pneumothorax. Twenty-two, or 81 per cent, had negative gastric contents on guinea pig inoculation. Five, or 19 per cent, had positive gastric contents. Of five pneumothorax patients with positive gastric contents, four had lesions in the uncollapsed lung.

Eight of the cases received pneumoperitoneum; four, or 50 per cent, had negative gastric contents. Thoracoplasties were done on six of the 44 cases. Three, or 50 per cent, were negative. Two cases that were treated by pneumothorax plus phrenic crush and pneumoperitoneum received gastric lavage. One was negative. These two cases each had a large cavity off the lower pole of the right hilum which could not close by pneumothorax alone. The one additional case in the 44 had a very extensive tuberculosis treated by pneumothorax, pneumonolysis and oleothorax. The gastric contents were positive. Of the 44 cases, 30, or 68 per cent, had negative gastric contents; 14 cases, 32 per cent, had positive gastric lavage.

TABLE IV

Results of gastric lavage and guinea pig inoculations on 44 sputum negative discharge cases.

	Negative	Positive
Pneumothorax—27 cases	22 or 81%	5 or 19%
Pneumoperitoneum—8 cases . . .	4 or 50%	4 or 50%
Thoracoplasty—6 cases	3 or 50%	3 or 50%

Since patients discharged with pneumothorax showed 81 per cent negative gastric lavage and those discharged with pneumoperitoneum or thoracoplasty had only 50 per cent negative findings, something should be said about the extent of pathology in these groups. The pneumothorax patients were far advanced in only 25 per cent of the cases. The pneumoperitoneum cases were 50 percent far advanced. Patients discharged with thoracoplasty were 100 per cent far advanced. In addition 50 per cent of the thoracoplasties had some degree of bronchial stenosis seen in bronchoscopy.

Obviously, this group of 44 cases is too small to allow any conclusive statements.

SUMMARY

1. A study of discharge standards in 21 sanatoria was made by questionnaire. Length of stay in sanatoria after x-ray lesions are stationary, cavities closed and sputum "negative" was compared.

2. Interpretation of the term "negative sputum" was studied.

3. Our own discharge standards were stated. Results of gastric lavage and guinea pig inoculation on 44 discharged patients who were either sputum free or who had been negative on a one-week sputum concentration and microscopic examination were reported.

CONCLUSIONS

1. The 21 sanatoria studied lack uniformity of discharge standards because of lack of agree-

ment on the term "negative sputum." Three-day concentrations with culture is the most usual test applied.

2. Of 44 of our discharge patients 30, or 68 per cent, had negative gastric lavage on guinea pig inoculation.

3. Patients discharged with pneumothorax showed 81 per cent negative gastric lavage. Patients with pneumoperitoneum and thoracoplasty had 50 per cent negative gastric lavage.

INDICATIONS FOR LOBECTOMY IN INSTITUTIONS**

JANE SKILLEN, M. D.

Olive View

IN 1939, Drs. J. J. Jones and Frank Dolley gave five indications for lobectomy in tuberculosis: (1) frequent, huge hemorrhage not otherwise controlled; (2) suppurating lung complicating tuberculosis; (3) persistent cavity with positive sputum following extensive thoracoplasty; (4) indurated, atelectatic, firmly contracted honey-combed lobe with positive sputum; (5) unilobar basal cavities which do not heal after the usual procedures of collapse therapy have been employed. Suspected malignancy in tuberculosis may be added.

Contraindications include active contralateral lesions, poor condition of the patient, and the absence of adequate attempts at other surgical measures.

This series of lobectomies consists of 4 cases with no deaths. The first patient was sent out for the operation to the Cedars of Lebanon Hospital in 1935 and has been reported by Drs. Jones and Dolley. Of the 3 lobectomies performed at Olive View, 2 were done in 1941 and 1 in 1942.

Our indications were (1) hemorrhage with suspicion of malignancy, (2) positive sputum from atelectatic upper lobe, following thoracoplasty, (3) large upper lobe cavity following a three stage thoracoplasty and (4) cavity remaining open after a three stage and anterior thoracoplasty.

DOMICILIARY CARE IN OLIVE VIEW INSTITUTIONS*

J. DWIGHT DAVIS, M. D.

Olive View

A CASE of pulmonary tuberculosis with silicosis and many extrapulmonary complications, under institutional care for nearly a decade,

* Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942. Abstract.
From the staff of Olive View Sanatorium.

** Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942. Abstract.
From the staff of Olive View Sanatorium.

is described. General and vague complaints are common in this type of patient. Very little medical and nursing care is required. A few of these individuals are chronically too ill to attempt any occupational therapy. Yet they must remain isolated. These are the "forgotten men." Because these individuals must be institutionalized over a period of many years they become discouraged. They must remain under isolation in an institution as they have no home facilities available which would be approved by the health department. They are placed in the institution under an isolation order. We as physicians must realize this, and treat these cases differently than the more acutely ill. Our responsibility is great.

In July, 1941, Olive View assumed an old C.C.C. Camp, which had been transferred to the Department of Institutions. Accommodations were quite inadequate, toilet facilities remote and an infirmary was available for only four patients. Infirmary units for 60 patients are being constructed; also available is bed capacity for 188 chronic cases. A garden project is contemplated. There are also a carpenter shop and shoe repair shop. Assignment of hours is planned for all ambulatory cases.

In addition to Olive View Camp at Acton, care is also given in several contract institutions, known collectively as the Olive View Outside Sanatoria. Those requiring bed care receive adequate attention in these institutions. Minimum standards have been established by Olive View for their care. Visiting physicians are assigned to various institutions. A mobile x-ray unit is employed and x-rays are taken at four-month intervals, or as indicated. Sputum specimens are collected routinely at four-month intervals and brought to Olive View for examination. Our full laboratory facilities are available for the Outside Sanatoria. Attending physicians see the cases in consultation, as at Olive View, and the same type of clinical conference is held for the staff.

Other groups of patients may be admitted to the Outside Sanatoria, such as: (1) Gravely ill patients, who have yet a life expectancy of some months, but in whom all methods of treatment have failed; (2) pneumothorax or other collapse therapy cases, who have shown satisfactory progress but still need further sanatorium care; (3) cases in which future surgery is indicated but in whom present contralateral lung disease precluded immediate operation.

The isolation of these chronic cases from the community eradicates a great potential source of tuberculous infection.

The annual death toll from tuberculosis in the United States would be more than 250,000 if the death rate of the early 1900's still prevailed. Under present mortality conditions, the annual death toll is about 60,000.

Control of tuberculosis demands not only everything the medical profession has to offer, but also active participation by the public.

THE SIGNIFICANCE OF A POSITIVE GASTRIC LAVAGE CULTURE ON DISCHARGE *

JOSEPH L. ROBINSON, M. D.
Olive View

A STUDY is presented of readmission rates for patients discharged from Olive View Sanatorium after gastric lavage examination. Of 307 patients discharged before January 1, 1941, 16 or 5.2 per cent have been readmitted. Those whose gastric lavage was negative before discharge show a readmission rate of 2.4 per cent, as compared to 17.4 per cent for those with a positive culture on discharge. Cavitation, and/or positive sputum, was present at the time of readmission in six of ten patients who had been discharged with a positive gastric lavage culture; in three, of six discharged with negative culture.

THE PROGNOSIS OF THE SO-CALLED "GOOD CHRONIC"***

FRANCIS M. JOHNSON, M. D.
Olive View

PROFESSOR Archibald apparently was the first to employ the term "good chronic case" in tuberculosis. Brown and Sampson suggested as criteria for a "good chronic" case that a "cavity two centimeters or more must be present. General condition must be favorable. Temperature and pulse must be normal over a period of several months. Appetite and strength must be good and the patient able to take some exercise. Expectoration may be present but not excessive." The number of tubercle bacilli in the sputum is not taken into consideration. It should be noted that this grouping of patients is based mainly upon clinical data.

Chronic fibroid pulmonary tuberculosis represents the pathology in the majority of these patients. Production of fibrous tissue is the predominant characteristic, due to the age of the lesion. Tuberculous complications occur less frequently than in the more acute forms. The symptoms are, with few exceptions, not pronounced. The majority of these patients give a history of illness extending over a period of ten or fifteen years. Treatment is mainly symptomatic, but some of these individuals may become candidates for thoracic surgery.

Patients are rarely free from symptoms and never well; most of the time they are able to be up and around and with symptomatic care are kept comfortable. Isolation is necessary in most cases.

* Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

*** Read before the Clinical Conference, California Trudeau Society, Olive View Sanatorium, April 9, 1942.
Abstract.
From the staff of Olive View Sanatorium.

THE PULMONARY ASPECTS OF CYSTIC FIBROSIS OF THE PANCREAS*

LLOYD B. DICKEY, M. D.
San Francisco

THIS entity has been recognized for some years, but I do not believe it has ever been formally discussed before this group. The respiratory symptoms and signs are the most startling part of the picture, and if these be present the prognosis is poor. The symptoms always develop in the first year of life, the patient is usually seen by the general practitioner or pediatrician first, and by the phthisiologist usually only in consultation. In any patient under two years of age, with a chronic respiratory infection extending from the tip of the nose to the alveoli, with sputum and a negative tuberculin reaction, cystic fibrosis should be thought of immediately, despite the fact that the diagnosis is made often only after necropsy. If suspected at all, the diagnosis can be made during life if a careful history be taken, and can be confirmed in many cases previously diagnosed as "chronic, or unresolved pneumonias," if the pancreas be sectioned at necropsy.

The first description of the pancreatic lesion was recorded by Landsteiner in 1905. In 1913, Garrod and Hurlley made a careful clinical study of a case of congenital steatorrhea in a boy of six whose brother died of bronchopneumonia at eleven months, after an infancy characterized by steatorrhea. No post-mortem examinations were recorded. Passini reported the first case of steatorrhea associated with a proved pancreatic lesion, the patient dying of bronchopneumonia at nine months. Necropsy demonstrated a fibrotic pancreas with acinar cysts. Siwe, in 1932, Benoit in 1935, and Tilling examined cases and confirmed diagnoses by examining the duodenal contents for pancreatic enzymes. On our cases we had not the facilities for these examinations. In 1938, Anderson reviewed the literature and reported cases. She considered the steatorrhea consequent upon the pancreatic deficiency as the cause of the deficiency of Vitamin A, and probably of D. She described the changes in the bronchial mucosa as the predisposing cause of the bronchopneumonia which is present in all cases coming to autopsy. The disease was common enough to be found in about three per cent of a series of necropsies at the Babies Hospital of New York.

There are now about one hundred cases reported with half proved by postmortem examination. The defective absorption of Vitamin A, suggested by Anderson, has been proved by Blackfan and May, and by others.

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 11, 1942.

Abstract.
From the Department of Pediatrics, Stanford University, School of Medicine.

A series of three cases is reported. The symptoms presented were chiefly those of early failure to gain on an adequate diet, with steatorrhea, and soon the symptoms of intermittent or chronic respiratory infection. These are the symptoms for which the patient is often brought first to the physician. The latter soon dominate the clinical picture. Sometimes, conjunctivitis is present. The child is underweight and there is abdominal distension. If the baby be premature the symptoms may be present very early as there is less Vitamin A stored in the tissues. In the diagnosis, the other diseases to be considered are lipid pneumonia, coeliac disease, asthma, the chronic specific infections such as tuberculosis, syphilis, coccidiomycosis, and unresolved pneumococcus pneumonia or pertussis. The differential diagnosis is made more easy by careful and thorough histories, laboratory examinations, clinical tests, and roentgen studies. An enlarged thymus or foreign body is often suggested, at least by the parents, as a possibility.

The pathological conditions present are, first, a primary fibrotic or cystic pancreas, probably of congenital origin as suggested by associated congenital anomalies and a frequently elicited familial history. The pancreatic ducts may be open or in a state of atresia. Either small multiple abscesses, bronchiectasis, often more marked in the upper lobes, or chronic pneumonia, or combinations of these are present if the patient comes to autopsy. Osteoporosis may be present if the patient lives into the second year, perhaps dependent upon deficient calcium and Vitamin D absorption. True rickets is usually absent probably because of the slowness of growth.

The treatment consists of supplying pancreatic enzymes and large amounts of Vitamin A by mouth, supplemented by further large amounts of Vitamin A intramuscularly. Banana powder, containing large amounts of invert sugar, is most easily absorbed in the absence of deficiency of natural pancreatic juice. Supportive treatment is essential, and sulfathiazole may aid in keeping infection lessened. Avoidance of exposure to infection should be rigid. One patient has been recorded as having lived 14½ years. Anderson has diagnosed ten patients by examination of duodenal contents for pancreatic juice. Of these, seven have died. Three are alive and well, between eighteen and twenty-four months of age, are gaining well and have largely or entirely recovered from their respiratory infections. She states that the prognosis is uncertain, but suggests that with the proper treatment, they may lead fairly normal lives.

As the pathological changes in the respiratory mucous membranes may in part be irreversible, obviously the most important single item in the treatment is its early initiation. This is dependent on its early recognition, the burden of which lies with the pediatrician and the general practitioner.

WHAT PATIENTS SHOULD BE TREATED AND BY WHAT METHOD? *

PAUL C. SAMSON, M. D.

Oakland

RATIONAL therapy is dependent on careful evaluation of both the tracheobronchial lesions and the subtending pulmonary tuberculosis. Fundamentals of bed rest and balanced high caloric diet must not be forgotten. Attention should be drawn to Bogen's report on the improvement of mucous membrane lesions following the ingestion of large amounts of vitamin C. It is recommended that this routine be followed as part of the general program. The use of general body radiation with ultra-violet light appears to have lost favor as a specific means of treating tracheobronchial lesions. There is the additional danger of exacerbation of the pulmonary tuberculosis.

DIFFUSE NONULCERATIVE NONSTENOTIC BRONCHIAL DISEASE

This type is characterized by congestion and edema of the mucosa, usually involving the orifice of the lobar bronchus and extending proximally in the stem bronchus. I suspect some of these lesions are non-specific. The majority are tuberculous however, proved by the later development of frank ulceration. Biopsy is contraindicated. Such lesions may well represent a type of allergic response in the mucosal and submucosal tissues. In general, no local treatment should be used. The pulmonary tuberculosis should be treated as indicated without regard to bronchial lesion.

FIBROSTENOSIS

The decision as to the employment of local treatment depends on whether or not symptoms are being produced by the stenosis. In the rare case of circumscribed stricture symptoms may be completely relieved by simple dilatation. More often, however, the stenosis is an irregular scar-tissue tunnel one or more centimeters in length, and dilatation is not effective. Kernan has had some success with copper bougies, using a negative galvanic current. In the presence of a stenosis the treatment of the pulmonary lesion must be carefully evaluated. In general, collapse pneumothorax does not yield good results. It is almost certain that complete and permanent atelectasis will follow, if there is any appreciable degree of stenosis. Fibrous stenosis is an irreversible process and we favor thoracoplasty whenever possible. If the patient has had trouble in expectorating prior to operation because of a stenosis, aspiration bronchoscopy has been employed routinely at the conclusion of surgery. In rare cases

Tuberculosis is a tremendous economic problem. Over \$70,000,000 was spent last year on hospital care alone.

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 11, 1942.

Panel Discussion,
From Alameda County Institutions.

where thoracoplasty is contraindicated it may be possible to use pneumothorax to help control a continuous harassing cough. Lobectomy, pneumonectomy or the external drainage of a tuberculous cavity may occasionally be necessitated because of high-grade bronchial stenosis, particularly: (1) If a technically adequate thoracoplasty has failed to control the tuberculosis; (2) if there are continued signs and symptoms of chronic pulmonary suppuration.

GRANULOUCLERATIVE BRONCHIAL DISEASE

We concur in the majority opinion that lesions of this type should receive actual local treatment. In early lesions, especially those which do not involve the whole circumference of the stem bronchus, there is every evidence that local therapy reduces the incidence of high-grade stenosis. Myerson, alone, feels that local treatment is of no value and that all tuberculous tracheobronchial lesions heal spontaneously. We cannot agree with this view. No collapse therapy of any variety should be used in the presence of an active or advancing ulcerative tuberculous bronchitis. If the lesion is at all diffuse, the application of from 10 to 20 per cent silver nitrate is of definite benefit. Prior to silver nitrate application the writer has often removed obstructing masses of granulation tissue by means of curette or cup forceps without undesirable sequelae. The immediate application of a coagulating agent to the more vascular base prevents any spread. Localized areas of ulceration or granulomas are accurately treated with the high frequency cautery. Kernan has reported the satisfactory use of a small mercury vapor lamp, endoscopically applied. The aspiration of retained secretions and the shrinkage of contiguous edematous mucosa with equal parts of 10 per cent adrenalin and 1-1000 adrenalin solution is of value in promoting adequate drainage. Local treatment may be repeated at from 14 to 21-day intervals. In addition to local therapy we are convinced of the value of a carefully graded course of tuberculin therapy. One cannot affect the deep tuberculous infection of the submucosa by endoscopic coagulation. Clinically, tuberculin therapy seems to aid in the more certain healing of bronchial ulceration.

When it becomes evident that the local lesions are regressing, attention can be given to the pulmonary tuberculosis. Again, we do not favor the use of pneumothorax because of the almost certain total and permanent pulmonary collapse which ensues. Where no contraindication exists, a multiple-stage thoracoplasty is the collapse procedure of choice.

Ulcerostenosis presents the combined problem of obstruction and active infection. Active local therapy should be directed at the ulceration even though there will be an almost certain narrowing of the stricture. An increase in the stenosis does not present as much hazard as the continued presence of active ulceration.

WHAT PATIENTS SHOULD BE BRONCHOSCOPED?*

J. LLOYD EATON, M. D.
Oakland

THERE seems little question that a tuberculous tracheo-bronchitis is a complication which makes the prognosis less favorable and complicates the treatment of pulmonary tuberculosis in general. Our own figures show that results from pneumothorax collapse are much less favorable.

To help clarify our own ideas as to the value of bronchoscopy in the type of tuberculous patients with which we are dealing, we did 219 bronchoscopies on 597 patients during the year ending July 1, 1941. Bronchoscopy was done on 71 patients with non-tuberculous lung conditions, but here we give a summary of conclusions and opinions on 148 bronchoscopies which were done on 93 patients with pulmonary tuberculosis.

The incidence of tracheo-bronchitis in our patients can only be estimated from this study. The group studied was heavily weighted with positive cases, as many of them were picked because of suggestive symptoms. The diagnosis was made if the patient showed symptoms of x-ray evidence of the disease, even though the bronchoscopic examination was negative, because we have all seen patients with typically blocked tension cavities but in whom bronchoscopy showed no evidence of the disease. Of the 93 patients studied, 54 had tracheo-bronchitis. These 54 patients are 11 per cent of all our patients. Estimating the number of positive cases among patients not bronchoscoped, from the percentage of positive cases found among the patients who were just routine bronchoscopies, gives an estimated incidence of 27 per cent. It seems safe to say that tuberculous tracheo-bronchitis is not a rare disease.

An analysis was made of the incidence of tracheo-bronchitis in relation to several factors. Considering its relation to the extent of the pulmonary pathology, we find that 62 per cent of the far-advanced cases had positive findings. Minimal and moderately advanced cases showed 46 per cent. When we compare the percentages of positive cases to the number of cases in each age group, we find no significant age differences. When we compare by sex we do find a significant difference. Females have a somewhat higher incidence than males. More females were examined in the young group and more positive cases were found there, while in males the same was true for the middle age group. However, in the middle age group (30-49 years), the positive findings were only half as frequent in males as in females. It is this marked difference in this age group which has weighted the totals to show a lower

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Abstract.

From Alameda County Institutions, Oakland, California.

percentage of tuberculous tracheo-bronchitis in males.

In analyzing our group for the value of symptoms and x-ray findings in the diagnosis of tuberculous tracheo-bronchitis, we used only the well-known symptoms and x-ray findings as described in the literature, and only those present before any collapse therapy was started. No single symptom stood out as being especially helpful and only 35 per cent definite symptoms. Positive findings were present in 67 per cent, shown by x-ray evidence. The two most valuable x-ray indications were atelectasis, and evidence of a partially obstructed cavity as shown by a round cavity which contained a fluid level at least part of the time or showed sudden changes in size. By using both symptoms and/or x-ray evidence, the diagnosis could be suspected in 81 per cent of our positive cases; these were the only findings in 22 per cent. On the other hand, 20½ per cent of the cases with no symptoms or x-ray evidence, were found to be positive by bronchoscopy. This percentage is probably high, as undoubtedly some of the cases included were picked for bronchoscopy because of certain symptoms or fluoroscopic evidence which were not recorded in the case histories. It would seem that symptoms and/or x-ray evidence are very helpful in making the diagnosis, but that, without bronchoscopy, a goodly number of cases will be missed. Without routine bronchoscopy, I do not know how to diagnose these cases before treatment has begun.

We have some evidence to show that missing such cases may not be particularly serious. Although admittedly the number of cases when broken down into such sub-groups is small, the majority showed relatively mild lesions of edema, congestion, or granularity of the mucosa, and these cases responded to ordinary pneumothorax collapse therapy in about the normal expectancy, although the courses tended to be stormy. The patients who were negative to bronchoscopy showed this same good response to treatment. On the other hand all but two of the 30 cases with bronchoscopic findings of the more advanced lesions, classified as tuberculoma, ulcerative lesions, or fibrostenosis, did show symptoms or x-ray evidence which would lead to a suspected diagnosis, and most of those in whom pneumothorax was tried responded unfavorably.

It would appear, then, that the bronchoscopic findings are of considerable importance in respect to treatment, and that the patients with symptoms and/or x-ray evidence of tracheo-bronchitis are the group in which bronchoscopy will be of the most value.

In 1912 tuberculosis killed one person every three and one-half minutes. Today, tuberculosis kills one person every eight and one-half minutes. Christmas Seal funds have helped in the saving of lives that these figures represent.

Early tuberculosis is readily amenable to treatment and recovery is easily possible.

ROUTINE CHEST FLUOROSCOPY GENERAL PRACTICE*

ALBERT C. DANIELS, M. D.
San Rafael

AS early as 1914, a tuberculosis case-finding survey of the Women's Garment Workers Union of New York City was made by physical examination method; 6 per cent of the male workers were found to have active disease. Similar surveys of various trade Unions were made in 1939 by Howard and his co-workers with a roentgenological technique which showed an incidence of 0.68 per cent.

Hahn reports an incidence of 8.3 per cent active disease discovered by x-ray in 1932 among the graduate nurses at Columbia University Hospital. Over a period of time from 1933 to 1940, the percentage dropped to 1.7 per cent. He also found that 0.9 per cent of medical students and 0.8 per cent of student nurses had active lesions when studied by x-ray.

Tice found an incidence of .13 per cent of active reinfection type in the children of Chicago of school age. He found 0.92 per cent of positive reactors to tuberculin to have significant lesions. The cost of about \$450.00 for each active case discovered, did not justify the means, in his opinion. Hutchinson and Pope confirm this in their Massachusetts survey which showed an incidence of .05 per cent and .08 per cent for male and female school children respectively.

In a survey of people who had been exposed to active tuberculosis in the household, Beekwen reports an incidence of .83 per cent. Graham, in a survey of 800 cases of pregnant women, reports a 1 per cent incidence of active, clinically significant disease. Data is not complete on the exact incidence of cases found in the survey of the draft inductees in the United States Army, but preliminary figures show the incidence of active pulmonary tuberculosis to be 0.97 per cent. Thus it may be seen that the incidence of tuberculosis in the general population is about 1 per cent.

In the county where I serve very little has been done in adult case-finding. In May 1941, the San Rafael branch of the Pacific Telephone and Telegraph Company requested a fluoroscopic survey to be made of their traffic force because of the discovery of two active, open cases of pulmonary tuberculosis among their members. Seventy-nine women of varying ages were so examined, and three more active cases were discovered; all were of an early parenchymatous type with no cavitation or positive sputum being present. Diagnosis was made in each case on x-ray confirmation of the fluoroscopic findings.

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Abstract.

From Marin County and Ross Hospitals, San Rafael, California.

Copy of complete paper may be secured from California Tuberculosis Association.

With the result of this small survey in mind, I decided to fluoroscope or x-ray every patient entering my office no matter what the original complaint might be.

This was begun in October, 1941, and since that time 250 patients have been submitted to examination. The fluoroscope has been used chiefly because of its ready availability and its low cost of operation. X-rays were taken of all chests which showed suspicious lesions on the fluoroscopic examination, and further attempts at diagnosis were made on suspicious cases by studying sputum, sedimentation rate, and history.

Seven active cases of pulmonary tuberculosis were discovered in this group of 250 patients, or an incidence of 2.8 per cent. One of these was missed entirely by fluoroscopic examination, and was picked up by the patient's local physician by means of an x-ray plate. A number of x-rays were taken for fluoroscopically suspicious lesions, which the roentgenogram proved to be non-tuberculous in nature. Such error is, of course, not vital, but it is important not to allow active cases to slip through undiagnosed.

This series of cases is as yet too small to justify breaking it down into groups of ages and complaints, or to draw conclusions as to percentages, but these seven active cases of tuberculosis were found in patients varying in age from 18 to 57. None of these cases gave a history of close contact with tuberculosis, and only one person suspected it. Four out of seven had positive sputum, while the other three had x-ray evidence of disease and increased sedimentation rates. In six of these seven cases, the chest was negative to ordinary physical examination, as interpreted by myself. In five cases there was no history that would have led me to suspect pulmonary disease.

In the seven previous years of general practice, I had discovered five active cases of pulmonary tuberculosis; an inquiry made of other doctors in general practice in this community indicates that they discover one or at the most two cases a year which they diagnose as active disease needing treatment. An inquiry addressed to the same physicians indicates that approximately 30 per cent of the general population consults some physician during the year for some complaint.

If we assume that the percentage of incidence of clinically significant tuberculosis is 1 per cent in the general population of Marin County, there are approximately 500 cases existing at the present time. If the present ratio of 2.8 per cent active cases found in a general practice should continue to hold good, then in the 15,000 patients who consult a doctor yearly, there should be about 400 cases of tuberculosis, or about four-fifths of the active disease in the community.

Here then is a fertile field for mass surveys. These people come to doctors because they feel they need medical aid. No problem of education or persuasion exists in getting proper chest examination, if the cost can be kept down. Con-

trast this with the efforts to get Union, industrial, and school groups educated to the point where a large proportion of their members will submit to examination, even though this examination is free. Thus it certainly seems that an effort should be made to survey this group of patients who are already seeking medical advice.

The means for doing routine chest examinations will vary, beginning doubtless with the use of the fluoroscope in the doctor's own office. Some further provision for x-rays of suspicious chests will need to be devised. The procedure will remove tuberculosis from the complete responsibility of the State and place it on the patient and his own physician, to the advantage of the patient in that his disease will be found early when prospect of cure is greater.

THE TREATMENT OF PULMONARY CAVITATION DUE TO COCCIDIOIDAL INFECTION *

WILLIAM A. WINN, M. D.

Springville

THE occurrence of pulmonary cavitation in association with primary coccidioidal infection has been described by Farness and Mills,¹ Carter,² Powers and Starks,³ and Winn.⁴ It is now evident that such cavitation is a part of, or residual to the pulmonary involvement produced by primary coccidioidomycosis. There should be no confusion with coccidioidal granuloma, which remains a relatively uncommon disease in which cavitation of this type is unusual.

During the acute pulmonary stage of primary coccidioidomycosis these cavities may appear and disappear in a comparatively short time. On the other hand, there is a marked tendency for them to persist, long after the acute pulmonary reaction has subsided, as residual, thin-walled, cyst-like structures.

These latent cavities continue to serve as reservoirs for the continued growth of the fungus, *C. immitis*, in its parasitic phase, manifested by the presence of endosporulating spherules within the sputum or contents of the gastric wash.

Coccidioidal cavities are usually solitary but may be multiple and occur in any area of the lungs. By fluoroscopy alone they serve as easily identified landmarks of the previous primary coccidioidal infection. Their usual thin-walled, "burned-out" appearance, with little or no surrounding parenchymal reaction has been so characteristic that we venture a diagnosis of coccidioidal cavity based upon the roentgenographic appearance alone.

Confirmation of the diagnosis is arrived at in

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Abstract.

From Tulare-Kings Counties Joint Tuberculosis Hospital, Springville, California.

the following manner:

(1) A suggestive medical history of residency of several weeks or more within the San Joaquin Valley or other known endemic areas. The frequent occurrence of single or repeated hemoptyses (nine out of 17 cases). Repeated episodes of productive cough are common, associated with chest pain of pleuritic type. The occurrence of erythema nodosum or multiforme in the past history is unusual. A striking feature in most of these patients is the lack of severe constitutional symptoms. They usually appear quite well and come to the clinic only because of hemoptysis, frequent "colds," chest pain or because of a chance roentgenogram disclosing the pulmonary lesion.

(2) Intracutaneous tests are then made using 0.1 cc. of coccidioidin in dilutions of 1:10,000 down to 1:100 inclusive. The test is exactly the same as the Mantoux procedure and is interpreted by the same standards with the exception that the peak of the reaction occurs in 36 hours. Routine tuberculin tests are also done, using freshly prepared solutions of Old Tuberculin or Purified Derivative down to and including the 1:100 dilution or the second strength. Extreme care is used in keeping separate the syringes, needles and sterilizing pans used for tuberculin from those used for coccidioidin skin testing. All cavity cases react to coccidioidin by the intracutaneous test.

(3) Sputum is often scanty in amount and may only occur during periods of respiratory infection or "colds." The chronic production of mucoid sputum also occurs but the amount is usually small. When sputum production is not obvious one may resort to gastric lavage. During acute primary coccidioidal infection sputum is usually a constant feature early in the illness but often disappears entirely long before the pulmonary lesion has cleared. It has been possible to isolate *C. immitis* from the pulmonary secretions in all 17 of our cases through the kind coöperation of Dr. C. E. Smith and his assistants of the department of Public Health at the Stanford Medical School. In each instance they have been able to confirm their findings by cultural and animal studies.

(4) This laboratory has also carried out our serologic studies. By using coccidioidin as an antigen they were able to demonstrate circulating antibodies in 15 of the 17 cases. We have considerable confidence in this particular laboratory test, having never obtained a false positive reaction, although we have sent a goodly number of serums as controls from conditions other than coccidioidomycosis, including tuberculosis, pneumonia and various miscellaneous disorders.

Having confirmed the diagnosis and, having ruled out tuberculosis which may be closely simulated, one must proceed with conservatism in any treatment directed toward such cavitation. Coccidioidal cavitation is practically always to be considered a part of the primary infection, either accompanying or residual to it. Primary coccidioidomycosis is very easily arrested within

the human body and only occasionally goes on to dissemination. The application of the rigid code of treatment used in dealing with pulmonary cavitation associated with tuberculous infection, is unnecessary. Persistent pulmonary hemorrhage or the occasional large cavity associated with constant production of spherule-laden sputum, may be indications for collapse measures. Pneumothorax has been used, with success, in two of our cases because of excessive bleeding. Another patient with a large thick-walled cavity who had two to three drams of positive sputum daily, has had pneumothorax for two years and still has spherules in his sputum although the cavity can no longer be visualized within the relaxed lung. In this particular case, however, we are now trying our best to re-expand the lung because of the continued existence of a fairly large complicating recurrent effusion. In two other cases that were given pneumothorax over periods of 2½ years and six months respectively, cavitation has remained open. Both cavities closed spontaneously after the lungs were re-expanded. The remaining 12 cases have received no collapse treatment and have been observed over periods of from four months to four years, under normal and unrestricted living and working conditions. Of these twelve, five have closed their cavities spontaneously and the remaining seven still retain their cavities with little change in the roentgenographic appearance and without evidence of dissemination.

A "hands-off" policy is indicated toward most coccidioidal cavitation, especially when characterized by the usual latent or thin-walled roentgenographic appearance. Conservative treatment is also indicated during the acute primary phase of the pulmonary infection when accompanied by cavity formation.

It is believed that residual pulmonary coccidioidal cavitation is only an infrequent manifestation of the primary coccidioidal infection. However, it is realized that, in an unknown but not insignificant number of cases, pulmonary cavitation must occur and disappear spontaneously. As yet, we have not seen either acute or chronic dissemination of disease in any of our cavity cases, most of which have been under observation for one or more years.

CONCLUSION

(1) The first step in the treatment of pulmonary coccidioidal cavitation is to differentiate the condition from tuberculosis.

(2) Bearing in mind the association of coccidioidal cavitation with the primary coccidioidal infection, conservative treatment is indicated.

(3) Persistent pulmonary hemorrhage or the occasional large cavity associated with continued production of spherule-laden sputum may be indications for simple collapse measures.

(4) From the standpoint of public health, it is not necessary to isolate the patient or separate him long from his usual mode of living or em-

ployment. The infection is not spread from person to person.

(5) Although primary coccidioidomycosis may occasionally become a progressive disease and acutely disseminate, or, through endogenous reinfection result in chronic dissemination (coccidioidal granuloma), we have not yet in our experience seen either type of spread result from the existence of untreated coccidioidal cavities, regardless of either continued sputum containing the fungus or hemorrhage.

(6) The above is based upon the follow-up observation of 17 cases of coccidioidal cavitation. Full confirmation of these conclusions must necessarily await the study of a larger series of cases.

NOTE: 47 lantern slides were used to illustrate this paper.

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DISAPPEARANCE OF THE TUBERCULIN REACTION IN CHILDREN UNDER TREATMENT FOR VARIOUS ALLERGIES*

F. M. POTTENGER, JR., M. D.

AND

F. M. POTTENGER, M. D.

Monrovia

IN primary tuberculous infection bacillary products escape into the blood stream and produce sensitization of body tissues to bacilli and bacillary proteins. Thereafter the tissues react with inflammation and exudation and other protective effects to each reinoculation of bacilli or bacillary protein (tuberculin).

The inflammatory reaction is termed "allergy," and as found in the skin is the basis of the tuberculin reaction. This is only one portion of a many-phased immunity mechanism. Allergic reactions are somewhat labile, varying under different conditions and at different times. When the tissues have developed a high grade of immunity sensitization decreases, and the allergic response becomes less marked.

In clinical tuberculosis the patient's ability to withstand larger and larger reinoculations with decreased local inflammatory reaction is a necessity if the patient is to live. It is necessary to

understand this variation in allergy in order to interpret properly the tuberculin reaction.

The immunity is an exaggeration of normal physiologic activity. It has been generally believed that although the tuberculin reaction may differ in strength from time to time, it rarely disappears entirely. Should it disappear frequently under any given set of conditions, and should the patient at the same time maintain a satisfactory degree of health during or after its disappearance such conditions would have to be considered as probably favorable to the patient. Inasmuch as the tuberculin reaction also may disappear during the loss of immunity which occurs in an advancing disease preceding death, and under conditions of cachexia, we must understand its disappearance as being both a favorable and an unfavorable sign, according to the conditions under which its disappearance takes place.

A series of forty-two children, some of which suffered from asthma, eczema, and other allergies, and others from low energy and delayed development, is reported in which positive reactions to tuberculin became negative during the time they were being treated with a high protein, high fat, and low carbohydrate diet; regulated exercise; and a potent extract of adrenal cortex.

Since increased permeability of tissues is known to be a factor in allergy, and since there is evidence that a high state of nutrition decreased permeability and also that the adrenal cortex has the same effect, and since the ability of these patients to react to tuberculin was either lost or reduced at the same time they were being improved or relieved of their other allergies, we must conclude that the treatment produced changes in physiologic resistance which lowered the sensitization of the tissues, thus making them less prone to react to tuberculin.

Approximately 36,000 civilians were killed in air-raids in England from June, 1940, to April, 1941. During a comparable ten-month period tuberculosis took 51,000 lives in the United States. Christmas Seal funds are our "home defense" against tuberculosis.

More than three million men, women and children have died of tuberculosis in the United States during the last thirty years. Over two million more would have died during that time if the mortality rate of 30 years ago had continued to prevail.

Tuberculosis killed more Americans in 1940 than were killed in action, or died from wounds received in action, during the First World War. Christmas Seal funds are used to reduce the toll of lives taken by tuberculosis.

The United States is gradually being freed from tuberculosis. In 30 years the death rate has been cut by 75 per cent. Christmas Seals have helped to finance these victories.

* Read before the California Trudeau Society and the California Tuberculosis Association, Los Angeles, April 10, 1942.

Abstract.

From Pottenger Sanatorium, Monrovia, California.

PROGRAM FOR WAR *

BERNARD C. BRENNAN

Los Angeles

THE California Tuberculosis Association has been organized and has existed for the sole purpose of rendering the greatest good to the greatest number in the public health field.

Two things happened on the 7th of December, 1941, so far as the California association was concerned. In the first place, we immediately offered our services to the United States Public Health Service and to the state and local health agencies. In the second place, we presented an added appeal for funds from the public, urging their increased giving in the Christmas Seal Sale then being conducted. A study of the chart indicates that the Pearl Harbor incident caused a lowering of the return for a few days until the appeal was heard by the public. The chart then indicates an increase so that the resulting net returns show an increase in the neighborhood of thirty per cent for the entire State of California over the preceding year. This is a recognition of the confidence the public has in the California Tuberculosis Association. With the honor and privilege accorded us in this recognition goes a corresponding duty and responsibility. We must use this money for increased service to the people of the State.

This additional service can be rendered in many fields and four in particular.

Expansion in Health Education: Added personnel, new type of services, efforts to reach individuals who can add to the service being rendered public health agencies.

New Phases of Education: We could add such items as emphasis on nutrition, dental hygiene, and coöperation in the various other services rendered by the public health agencies.

Special Service to Armed Forces: In following up those who have been rejected because of health, and in contact with families of our armed forces.

In the Industrial Field: Taking on added responsibility in industry for their own problems. In this connection, attention should be called to the new agricultural conditions which may add to our tuberculosis load. Men not used to this type of work will be called into service by reason of the evacuation of enemy aliens made necessary. This relating of services to the vital necessities should not be overlooked.

In general, our men are fighting for the civilization built up over many generations. Part of that civilization is the service rendered by such voluntary organizations as our California Tuberculosis Association. It is our responsibility here at home to protect that portion of our civilization which is effected in the realm of our activities. In that way we can take care of our share paralleling the efforts of those at the front.

If we are to go back to the public and expect a continuance of their confidence in the form of increased giving in the forthcoming Christmas Seal Sale we must merit that confidence by the service rendered during the current year. Let us keep in mind the necessity of gearing our thinking, our programming, our services and activities to the greatest good for the greatest number in the light of the emergency created by the war condition.

TUBERCULOSIS PROBLEMS IN INDUSTRY *

W. P. SHEPARD, M. D.

San Francisco

IT IS the purpose of this paper to review the effects of war on tuberculosis; to study some of the contributing factors which may account for the increase of tuberculosis during war; and to point out the large responsibility shared by industry and the medical and public health professions for the prevention of this serious menace.

WAR AND TUBERCULOSIS

Lest some may think "it can't happen here," let us see what is happening in countries now at war. In Canada war's impact, although at some distance, has already been felt for nearly three years. Among the Industrial policyholders of the Metropolitan Life Insurance Company who number over one million in Canada and whose death rates have closely paralleled those of the general population, there was an increase of 18.7 per cent in death rate from all forms of tuberculosis in 1941 over 1940. Whether this is actually attributable to the effect of war cannot be proven at this time. Death rates for the first two months of the year are more favorable. Nevertheless, this is a significant increase among a population group showing consistent reductions for many years.

In England and Wales between 1939 and 1940 the tuberculosis death rate among the general population increased 13 per cent among males and seven per cent among females. In Scotland the increase was 14 per cent.

Statistics from Germany and the occupied countries are now unavailable, but Vichy France reports a sharp increase in tuberculosis, and there is good reason to believe Germany is showing an increase.

During the last war none of the belligerent countries escaped an increase in tuberculosis. Among German women the death rate increased 75 per cent between 1913 and 1918. In Brussels the death rate increased from 177 per 100,000 in 1914 to 390 in 1918. In Warsaw the rate in-

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Assistant Secretary and Pacific Coast Welfare Director, Metropolitan Life Insurance Company, Clinical Professor of Public Health, Stanford University.

* Read before the California Tuberculosis Association, Los Angeles, April 9, 1942.

From the Los Angeles County Tuberculosis Association.

creased from 306 in 1913 to 840 in 1917; in Cracow, from 407 to 908. In Belgrade the tuberculosis death rate in 1918 was 1,400 per 100,000.

Even the neutral countries did not escape. In the Netherlands the 1918 rate was 50 per cent above 1914. In Switzerland the increase was six per cent between 1914 and 1917. In our own country, brief and relatively easy as our participation was, the original registration states showed an increase from 134.8 tuberculosis deaths per 100,000 in 1916 to 151.0 in 1918, an increase of five per cent.

There can be no doubt that war and tuberculosis go hand in hand. We cannot stem the tide of war now except by making every sacrifice necessary to attain victory in the shortest possible time. Can we stem the tide of tuberculosis meanwhile? Let us examine some of the causes.

CONTRIBUTING FACTORS

Among the factors contributing to increased tuberculosis deaths during war are the following:

Food Shortage—due to destruction, decreased production, or a decrease in “real wage.”

Overcrowding—due to destruction of homes, housing shortage, dislocation of large population groups, or decrease in “real wage.”

Inadequate Medical and Public Health Facilities—due to destruction or confiscation of sanatoria, inadequate support of health departments, diversion of medical personnel to combat services, or decrease in “real wage.”

Demands for Increased Work—due to the necessity of enormous increase in production and shortage of man-power in industry.

We know that tuberculosis is an infectious disease whose spread and whose disabling effects are enhanced by poverty, fatigue, malnutrition, and inadequate medical and public health facilities. These bring about the attendant dangers of overcrowding, increased contacts, inadequate rest, lowered resistance, improper diet, missed cases. If the war imposes sacrifices so great as to make it impossible to avoid these dangers, then a rise in the tuberculosis death rate is inevitable.

But this is a land of plenty for all. The necessity of such extreme sacrifices now seems unlikely. Food shortage in the sense that there are insufficient articles to provide a well-balanced diet seems improbable. Overcrowding due to destruction of vast numbers of homes seems unlikely. Less adequate medical and public health facilities than we now have, need not occur if we are aware of the importance of preserving the health of civilians. “Real wage” will be preserved if we can maintain a wise national economy.

Our immediate danger so far as tuberculosis is concerned lies rather in our being unaware of certain health essentials which we might sacrifice thoughtlessly. Among these are the proper conditions under which the necessary increased work will take place. This is largely in the field

of industry. In fact, assuming that production of food, proper housing, health facilities and the value of the “real wage” will not be destroyed, then one of our major efforts in the control of tuberculosis during the first years of the war will be in coöperation with industry.

WORKING CONDITIONS

By “industry” is meant the whole complex of industrial management, union as well as owner control. Working conditions are largely the responsibility of industry, aided by wise governmental supervision, and guided by skilled and available medical advice.

Bearing in mind that industry's problems are enormous, we must be prepared to give them sympathetic and effective help to avoid the dangers we know from experience will increase the tuberculosis death rate.

DANGERS TO BE AVOIDED

Dangers to be avoided in industry are:

Longer Work Hours. Individual capacity for sustained work, regardless of whether it is light or heavy labor, varies enormously. All individuals reach a point, however, beyond which they cannot continue working without detriment to health. The 40-hour week seems well within this limit, even for the least robust. It might even be increased some without harm, but to encourage or even permit men and women to work 10 hours a day 7 days a week is dangerous from the health standpoint. This danger is not mitigated by time-and-a-half or double-time pay. Except in the direst emergency, the length of work hours must be kept within health protective limits.

Inexperienced Help. It is an old observation among foremen that “the green hand sweats the most and does the least.” War production will pull into industry many young people not accustomed to continued arduous employment. Many will be young girls. Many will come from rural areas without the immunity commonly attributed to city dwellers. They are the age and sex group in which tuberculosis is most prevalent. Others pulled into industry will be those hitherto resting comfortably on relief, many of whom had latent or quiescent tuberculosis which will be activated by going to work. These groups, until they become skilled or are medically classified will “sweat the most and do the least,” be paid the least, be driven harder by the pressure for more production. They need close medical observation. Will they get it?

Lessened Health Safeguards. It is the rare factory that can change over from peace to war products, expand a thousand per cent, adapt itself to governmental regulations, speed up unit production, and still maintain its health safeguards for employees. Industrial medical programs are usually evolved over a period of years and are best developed in the older, better established industries. Many of these war industries are brand new from the top down. We have here all the makings of a vicious circle: inexperienced

employees of an age particularly susceptible to tuberculosis, new industries with undeveloped health safeguards, no provision for locating early cases of tuberculosis, increased contacts and more tuberculosis.

NECESSARY HEALTH SAFEGUARDS FOR INDUSTRY

Every physician or nurse given an opportunity to make recommendations to these industries should stress the importance of the following:

Pre-employment Examinations. These are necessary to avoid subjecting those with physical handicaps, including unrecognized tuberculosis, to work which will aggravate their condition. The examination should include special measures to detect tuberculosis.

Periodic Health Examinations. All employees should be examined annually. Those who require examination more frequently than once a year include: those in hazardous occupations and those whose behavior deviates from normal. The periodic health examination is still our best method of picking up early tuberculosis as well as other early physical handicaps which lead to more serious conditions if neglected. If the periodic examination includes an adequate chest examination, it is especially valuable.

Industry should be informed that local tuberculosis associations in this State can arrange through the California Tuberculosis Association to provide a portable fluoroscope and competent medical examiners for this purpose. Arrangements can also be made through the Industrial Hygiene Service, State Department of Health, to obtain the loan of fluoro-photographic outfits for taking small chest films. These outfits are loaned to states by the Bureau of Industrial Hygiene, United States Public Health Service, Washington, D. C.

Compliance with Well Established Standards for ventilation, illumination, sanitation, safety and freedom from toxic hazards. This may require close coöperation between the engineering and medical departments, and once established can only be maintained by constant inspection.

Dispensary and First Aid Rooms. A medical headquarters containing modest equipment for the treatment of minor ailments and for rendering first aid is essential. This soon becomes a medical headquarters where those with minor complaints and health problems may find sound medical and nursing advice readily available.

Employees' Health Education. Some plan of health education of employees including safety, nutrition, and personal hygiene is important. Proper nutrition is almost solely an educational problem. Our present prevalence of malnutrition is due to lack of education rather than scarcity of the components of a well-rounded diet.

Responsibility of Foremen. If industry is aware of health needs among employees and if effective work is to be done, the foremen are easily taught to keep a close watch on the people working directly under them and to refer to the Medical Department those who show ab-

normalities such as undue fatigue, loss of weight, nervousness, or manifest illness.

Health During Non-work Hours. Industry may legitimately interest itself in what happens to its employees during non-work hours. While it is true that the employer has no legal responsibilities once the employee leaves the plant, and most employers have no desire to be paternalistic, nevertheless it is also true that much absence due to illness originates in faulty personal or domestic hygiene and in many plants more lost-time injuries take place during off-hours than on the work premises. Men who drive 50 miles from home to job because of housing shortage near the plant or those whose only home is in their car or in a tent can hardly be expected to do their best work. These are not direct responsibilities of industry, but the employer's and the union's influence on the individual or on local housing and health authorities will often expedite remedies for situations which increase health hazards.

Plant Cafeterias. Well operated plant cafeterias serving a hot meal at cost or at company expense often go a long way toward correcting serious nutritional problems. Experience has shown that one well-balanced meal a day can be served economically and it pays dividends in improved health.

Rest Periods. Especially where the work is monotonous, rest periods, even though as short as five minutes and even though provided but twice a shift, will often increase production. Certainly they are an added safeguard to health.

Rotation on Night Shifts. Those who are to work on night shifts should be recruited from more experienced employees at first and rotated not less than every three months. Most workers become accustomed to night work in a short time, but their day sleep is shorter and less restful. Youngsters are especially inclined to sacrifice rest for the pleasure of social activities.

Prevention of Silico-tuberculosis. Some industries, especially the newer and smaller ones, need to be reminded that finely divided silicon dioxide or silica inhaled by workers is a direct cause of tuberculosis and is compensable. There is no need for a "dust hysteria." Most dusts, fortunately, are well handled by the respiratory tract. So far as we know now, silica is the major tuberculosis hazard among all the dusts, fumes and gases. Lanza says, "It has been customary to associate a high incidence of tuberculosis with the dusty trades, but aside from exposure to silica, a casual relationship with reference to dust has been assumed rather than proven." Even this to be harmful must exist in finely divided form and must exceed 5,000,000 particles per cubic foot to be dangerous. It is important to review the wide range of industries in which exposure to silica may take place.

APPROACH TO INDUSTRY

These are the items of constructive advice we should be prepared to offer industry at each opportunity. One word of caution is necessary,

however, on our approach. It is of little avail to pound on the gates of industry shouting advice which comes from strangers who have little knowledge of industry's problems. To industry, production is of first concern and health is often secondary. When they do consider health, it is health as a whole, not as tuberculosis, venereal disease, or malnutrition. Most often their first health concern is with safety or with specific hazards arising from their processes, such as lead poisoning, silicosis, dermatitis.

The health problems of industry, including tuberculosis, are all covered in the rather highly specialized field of industrial hygiene, which is the application of public health methods to industry. The California State Department of Health has a well organized and efficiently operated Industrial Hygiene Service. It is well equipped and staffed with experts in medicine, chemistry, and engineering. It works closely with the Industrial Accident Commission and the Workmen's Compensation Board. It is being well received by industry throughout the State, has ready entree to industrial councils. In addition, several county and city health departments have well organized bureaus of industrial hygiene which work closely with the State. Unless some unusual opportunity occurs, it is usually better to approach industry through these official agencies, rather than to make a separate approach concerning tuberculosis alone. Industrial hygienists are as much concerned with the control of tuberculosis in industry as we are and will often welcome the facilities available through the local tuberculosis association.

SUMMARY

To summarize, war and tuberculosis go hand in hand. We are better prepared than ever before to attempt control of tuberculosis in this war. To do so will require increased effort and continued financial support. If victory requires such extreme sacrifices as large destruction of food supplies, homes and the value of the "real wage," and if it requires serious curtailment of adequate health facilities for civilians, then a great increase in tuberculosis is inevitable. Assuming that such extreme sacrifices can be avoided, then war tuberculosis can be largely controlled. One of our most important fields of endeavor must be in industry where many of the conditions originate which contribute to the rise of wartime tuberculosis.

The x-ray is one of the most important weapons this country has for civil defense.

"The battle against tuberculosis is not a doctor's affair, it belongs to the entire public," said the famous Sir William Osler.

One of the greatest achievements of the 20th century can be the eradication of tuberculosis in the United States.

ADMINISTRATION OF CASE FINDING IN INDUSTRY*

E. P. VON ALLMEN
Oakland

OF ALL the newly-reported cases of re-infection type tuberculosis in Alameda County last year, 89 per cent were over 20 years of age.

Since most of the people over the age of 20 will be found at work, it is important to tuberculosis control to try to find the people in the adult population who have tuberculosis and place them under treatment.

In the summer of 1939, it was decided by the Alameda County Tuberculosis Association to offer fluoroscopic chest examinations to people employed in industry. Our surveys to discover the proper place to begin were made of 24 adult groups, ranging in size from 100 to 1000 employees.

That suggests the way to start such a program is by choosing the logical groups. A part-time plant physician may be interested in a survey, if approached by the proper person. Or, the opportunity to serve may result from a letter in plain English to the key person in the firm, describing the *free* service which tuberculosis associations can offer.

Your health department can be asked to work with you. The Department can suggest plants in which it would be a good idea to have such service offered.

Put the personnel officer of your local industrial firms and the industrial nurse on your mailing list for your monthly news bulletin, so that they will know what you are doing.

Eventually the news will get around that your Association provides this service and requests will come to you. From here on it is a coöperative effort between your association and the industry.

The routine work has been carefully worked out and from this experience other associations may be helped in making plans for such a project.

PROCEDURE USED

In fluoroscopic surveys equipment is moved to the plant; a room is darkened for the survey and employees are routed in small groups to this room for examination.

RESULTS AND COSTS

In the recent fluoroscopic screening of 5,611 adult persons, 120 were considered for further study.

Of this number, 76 persons, or 1.4 per cent, required medical treatment for tuberculosis or other pathology found; and 27 of these persons had active pulmonary tuberculosis.

* Read before the California Tuberculosis Association, Los Angeles, April 10, 1942.
Abstract.

From the Alameda County Tuberculosis Association.
Copy of complete paper may be secured from California Tuberculosis Association.

Sixty-four, or 84 per cent of the 76 persons with pathology were referred to 36 different private physicians and 12 persons, or 16 per cent to clinics.

The total cost of the 5,611 examinations was \$2368.18, or 42 cents per person.

The cost of discovering each of the 76 persons needing medical attention was \$31.16; the cost of finding each case of active tuberculosis was \$87.71.

REPORTS TO EMPLOYEES AND EMPLOYERS

Considerable care needs to be taken with regard to reports on these examinations. These are regarded as confidential and only the employee concerned is given the findings on his own examination.

This is usually the understanding with the employer at the start. If the employee has tuberculosis and refuses treatment, the matter is then in the hands of the City Health Department for adjustment.

THE PROBLEMS OF TUBERCULOSIS ARE SOCIAL AS WELL AS MEDICAL *

WILTON L. HALVERSON, M. D.
Los Angeles

SUPPORTED with the findings revealed through a study conducted in Los Angeles County, we have tried to demonstrate the need for medical social case work in the care of tuberculous patients.

The problems which face the tuberculous patient are social as well as medical. Tuberculosis implies long term medical care and disability, total or partial. Chronic illness affects a patient psychologically. It changes his financial and social circumstances. The news itself is frightening. More often than not he needs aid in removing obstacles that stand in the way of his accepting the doctor's recommendations for treatment. Too often he rationalizes to the effect that perhaps he does not have tuberculosis, and seeks verification of his wishful thinking through some other doctor, not always a doctor of medicine. Or, he decides he is not really sick enough to inconvenience his family economically as yet, and drags on.

If these people are worthy of the expense of diagnosis and appropriate medical care, involving long-term sanatorium care, they are also worth the expense of proper social care. This should include a consultation service and guidance if the patient wishes, from a well-trained medical social worker. If this is offered at the time the medical diagnosis is made, it will help to adjust difficult social situations during the waiting period for sanatorium care, and is likely to bring

him to the sanatorium in a more hopeful mental attitude. Social care should run concurrently with medical care.

In the Los Angeles County Health Department, we have had since 1927 a small staff of medical social case workers for the purpose of helping patients with other problems arising out of their need for medical care. It is department policy to offer each patient the opportunity of an interview with a trained medical social case worker, at the time of a positive diagnosis for either tuberculosis or venereal disease.

The aim of the medical social worker in this first interview with the patient is to find out how the patient has accepted the diagnosis; what it will mean to himself and his family; whether he understands the examining physician's recommendations; whether he expects to carry through on the recommendations; whether he wishes help in developing a plan of care; whether care can be arranged through private medical practice, or whether it need be arranged through other community resources or through the services of the County Health Department. This application of medical social work skills at the point of medical diagnosis and recommendations for care, when the patient is faced with the reality of the problems created by the discovery of a potentially disabling communicable disease, is of value to the patient. It is equally as important to the administration of the public health program and to the future medical economics of the community which eventually pays the bill for the neglected chronic, disabling diseases.

Recently, the Los Angeles County Health Department completed a study of 162 patients who had a positive sputum as of June 30, 1940 and were residing at home. The objective was to understand why these patients were not under institutional care. Of the 162, about 83 per cent (134) were eligible under the provisions of the California Welfare and Institutions Code for county institutional care. Of the total, 24 or about 15 per cent had been recommended for, and were awaiting sanatorium placement; 138, or about 85 per cent, were not being recommended for institutional care. An analysis of the "reasons" why placement was not recommended by the attending physician at this time showed the following:

	Patients	Percentage
Available care at home considered satisfactory from a medical standpoint	78	56.6
Patient unwilling to leave family group	18	13.1
Ex-sanatorium patient, unable to adjust to institutional care.....	12	8.6
Patient fears recommended surgery and medical care for which he was referred to sanatorium.....	18	13.1
Patient unwilling to comply with the provisions of the California Welfare and Institutions Code....	4	2.8
Patient unwilling to accept diagnosis of tuberculosis	6	4.4
Patient feels there is racial discrimination at the County Sanatorium	1	0.7
Reason not given.....	1	0.7
Total	138	100%

*Read before the California Tuberculosis Association, Los Angeles, April 10, 1942.
Abstract.
Health Officer, Los Angeles County.
Copy of complete paper may be secured from California Tuberculosis Association.

The group of 78 patients for whom home care was considered satisfactory *medically*, was composed of those receiving pneumothorax in the Health Department chest clinics; those whose condition was more or less chronic, for whom no special institutional care was prescribed; and those whose condition was so far advanced, even to the terminal stage, that institutional care was not considered essential to benefit the patient.

The remaining 60, or 43.4 per cent, with one exception, had reasons of a *social* nature for not accepting institutional care.

Another problem of the tuberculosis control program results from patients who leave institutions against medical advice. This is partially controlled during the infectious period by serving an isolation order on each infectious patient institutionalized. With the passing of the infectious period this order must be rescinded by the public health department, and the patient retained, if at all, by persuasion.

Reasons given by patients leaving the institution against medical advice included:

Fear that the wife or the husband at home is "stepping out" with someone else, and in order to prevent family disintegration the patient thinks it important to return home.

Fear that the adolescent daughter at home is not being properly "supervised," or that the adolescent boy at home is "getting into trouble."

Fear of accumulating institutional indebtedness in spite of assurance that he will not be pressed for payment until financially able.

Dissatisfaction with the food, housing, or general care offered in some institutions, accompanied with much resentment toward the Health Department for removing the patient from a home he believes far more satisfactory than the institution to which he was sent for purpose of "getting well."

In many instances the reasons given by the patient are based on his emotions which have been so agitated by his experience that intellect has been almost entirely submerged. There is a real need for a wider use of intelligent social treatment to prevent the development of these problem cases.

At this time when man-power is at a premium, it is our bounded responsibility to supplement modern case-finding endeavors, and excellent medical care, with a carefully planned and executed social treatment program.

"Education of the people, and through them of the state, is the first and greatest need in the prevention of tuberculosis," said Dr. Edward Livingston Trudeau, first president of the National Tuberculosis Association.

* * *

The tuberculosis germ has been the target of more clinical and biological research than any other microbe.

* * *

The health of a community can be bought with dollars and cents.

THE MEDICAL SOCIAL WORKER IN A TUBERCULOSIS ASSOCIATION*

E. P. VON ALLMEN

Oakland

THE Tuberculosis Associations can perform a valuable service to the community by having on the staff a full-time, well qualified medical social worker.

QUALIFICATIONS OF WORKER

This worker should be chosen with regard to maturity, poise, personality and training.

HER DUTIES

This worker's services should be freely available—to the private physicians of the community who wish her assistance in specific problems; and to any patient or individual who has a tuberculosis problem with which he needs help.

COOPERATION WITH PRIVATE PHYSICIANS

In our county there are 842 licensed physicians and surgeons. If I walk into the office of one of these men and he makes a diagnosis of tuberculosis in my case he has probably completed the immediate task before him. He will undoubtedly then recommend that I obtain sanatorium care.

The next move is up to me. But suppose I do not know where to go, how to go, how to pay for my care, what to do about my family while I'm in the sanatorium?

Obviously to answer all of these questions requires more time than the private physician concerned with my medical condition can give to these non-medical aspects of my case.

If, then, my doctor can call the office of the Tuberculosis Association, and refer me to a well qualified medical social worker who knows or can find the answers to my non-medical problems, he has been helped, I have been helped and the Tuberculosis Association has rendered us both a constructive service.

In Alameda County about 45 per cent of our cases are referred to us by private physicians. These physicians know the social worker personally, the program of the Association and what they may expect in the way of assistance from the Association.

The medical social worker is prepared by training and experience to act with the doctor as an interpreter to these troubled families, and to assist in the reorientation of the family group to the changes with which tuberculosis has confronted them. Specifically, she will find out what problems, financial, special or even psychological have been presented by the diagnosis to the family unit as represented by the doctor's patient, and it will test her skill to help the patient and family over

* Read before the California Tuberculosis Association, Los Angeles, April 9, 1942.
Abstract.

From the Alameda County Tuberculosis Association, Oakland, California.

Copy of complete paper may be secured from California Tuberculosis Association.

these difficulties. She will recognize this situation with respect to the long range aspects involved, beginning first with diagnosis, extending through sanatorium care and then to the return home and the resumption of the former or a new occupation.

She knows the community resources and what may be expected of them; she knows approximately what to expect with reference to the patient's eventual return to his family and whether it may then be necessary to help the patient into an entirely new occupation or whether he may resume his former job. She knows about the other members of the family and she tries to make sure that those who have been exposed to infection are placed under periodic medical supervision.

COOPERATION WITH PATIENTS

Not all patients are referred by physicians. Many of them apply to the Tuberculosis Association under their own power and of their own volition. Some are referred by friends of other agencies.

Some of the problems presented are those of people who are caught in the "no man's land" which exists between the institutions for the care of the indigent and the facilities for private medical care. They are ineligible for the first and unable to pay the full price of the second. For these persons part pay arrangements can be made if the financial situation justifies.

Very often the matter presented by the person applying is just a downright tough individual problem which the person can talk out with a worker who has sense enough to listen quietly. When this has been done the worker may be able to tap the necessary resources which help the individual to iron out his own trouble.

In the cases of these office applicants there is often need for a vast amount of interpretation to people who fail to understand exactly the significance of the problems which they face. Within the proper scope of her duties, the medical social worker may make these interpretations.

WHAT TUBERCULOSIS WORKERS SHOULD KNOW ABOUT HEART DISEASE *

HOWARD F. WEST, M. D.
Los Angeles

ACCORDING to the National Health Survey of 1935-1936, the incidence of heart disease is five times that of tuberculosis. If those with potential heart disease, arteriosclerosis, and high blood pressure are included the incidence would be ten times that of tuberculosis. This group heads our national mortality lists and contributes heavily to acute and chronic illness.

* Read before the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.

President, California Heart Association.

Copy of complete paper may be secured from California Tuberculosis Assn.

Heart disease, like tuberculosis, may cause acute illness requiring varying periods of bed rest, constant supervision and nursing care; it may cause prolonged periods, perhaps many years of chronic disability, or it may act only as a limiting factor requiring adjustment to physical activities, working strains, and so forth. Also like tuberculosis there may be more or less complete recoveries from heart damage followed by long years of useful life.

Like tuberculosis, the social component of heart disease is a large one. With nearly seven and one-half million people involved or potentially involved it is actually enormous. The financial factors are almost staggering. Beginning with an estimated \$250,000,000 loss in wages per year we must add the costs of medical, hospital, and nursing care. Psychological problems are almost as important as financial. These may lead to difficulty in adequate control and consequent relapses. Fear and apprehension may lead to unnecessary limitations and medical expense. The social worker finds her greatest usefulness within these two broad fields of the economic and psychologic aspects of the disease.

It is the important subdivision of rheumatic heart disease that furnishes the closest analogy to the problems of the tuberculosis worker.

Rheumatic heart disease accounts for approximately 25 per cent of all heart deaths. It accounts for 90 per cent of heart disease under 30 years of age. Like tuberculosis it results in maiming and death during the period of greatest social and economic usefulness. It is the chief and really the only serious manifestation of the infection known as rheumatic fever.

Rheumatic fever is an infectious disease. The causative agent has not been definitely identified though certain forms of the streptococcus and filtrable viruses have been under suspicion. There is considerable evidence that it may be transmitted from person to person through discharges from the upper respiratory tract. Multiple cases in families, localized epidemics and waves of rheumatic activity in cardiac hospitals are seen. Symptoms are sometimes so mild that in from 50 to 75 per cent of cases of rheumatic heart disease, they are not remembered. However practically all valvular heart disease in persons under thirty years of age is due to rheumatic fever. The original infection occurs most frequently in childhood. Instead of conferring an immunity it increases the individual's susceptibility to subsequent invasion. Approximately 80 per cent of children under ten years of age have subsequent attacks.

Early and continuous care can do much to protect and minimize heart damage in rheumatic fever. The long convalescent period requires intensive training of both child and parents in the proper psychologic approach both to the more acute phases of the illness and to subsequent degrees of disability. Avoidance of strain without undue invalidism should be the guiding principle.

Prevention of rheumatic fever even though the causative organism and immunization possibilities are not yet known is our aim. General improvement in the standards of living would go far toward this accomplishment. The frequency and severity of heart damage would be greatly lessened by prompt diagnosis and adequate treatment. This requires more intense and more widespread education of the professions and of the public to a better understanding of the principles involved and the realization that here is a Public Health problem of major importance.

VOCATIONAL TRAINING FOR THE TUBERCULOUS*

JOSEPH O. STANTON

Los Angeles

A WELL-DEFINED rehabilitation plan for the tuberculous ends with vocational training and remunerative employment. It should begin the day the patient learns from his doctor that he has tuberculosis.

During the first weeks of illness, a broad rehabilitation plan, stressing mental hygiene, should be introduced. The patient should be made to realize that some day he will be expected to return to normal society and a job. After he has made some adjustment to sanatorium life, the patient should be given a selected reading plan, followed by educational courses to fit his needs. Under the influence of a well-developed counseling plan, the patient is spared the torment of an insecure future.

That he has an opportunity for counseling and training should be made known to the patient early in his sanatorium stay. When he goes out of the sanatorium, he need not be faced with the dreary round of hunting for and finding the wrong kind of work which will eventually lead him right back to the sick-bed.

The real problem of the training and counseling, however, must await word from the doctor as to the feasibility of such training. Patients are of two kinds, those whose ambition pushes them to making a move toward rehabilitation before they are physically able, and those who lack ambition and refuse all help, building up a pity-complex. Also, there are the persons who have definite ideas of what they want to do and who are mentally or emotionally unsuited to the job they choose. These adjustments must be made while the patient is in the sanatorium. Quite as many patients ask for too little, as those who ask too much. Oftentimes, the counseling service finds a person suited for a much higher grade job than he feels he can fill. Here is another adjustment to be worked on.

A great variety of training is provided so that with careful analysis of the patient and his abilities, he may be trained and prepared for any job for which he is suited. Basic education is provided as well as job training.

One difficulty facing tuberculous patients is that unlike other handicaps there is no time limit on his disability. Tuberculosis stubbornly refuses to be put on a time schedule. That causes various interruptions of his training, and here again a fine piece of adjustment work must be done to keep the patient interested and aware of his opportunity even though the course of his training is interrupted.

Recent reports on rehabilitated tuberculous patients have been made and the case histories are encouraging. The training and placing of these people in jobs is also proved as economical. The largest group of people surveyed was the group of 436 cases, surveyed by Harry D. Hicker, chief of the State Bureau of Rehabilitation. Trained for 134 different occupations, these clients were rehabilitated at an average cost of \$105.05.

SOCIAL SERVICE IN A SANATORIUM*

SIDNEY MELINKOFF

Los Angeles

THERE is no need to justify the importance of a social service program. That matter is common knowledge. In this paper, we shall, rather, try to lay down a few rules as guide for the functioning of a social service program in a sanatorium.

The social service program has one objective, to get the patient back into the stream of life as a self-sufficient, productive member of society. The program must, therefore, consider the individual's background, social, economic, educational, occupational and avocational, as well as his native or acquired interest and abilities.

There are three phases to the social work program; case work and psychiatric case work services, vocational rehabilitation and job placement.

The case work program, as shown by surveys of such services, covers many things, anything in fact which touches the life of the individual and which may make his cure less speedy and his return to normal life less sure.

Recreation is an important part of the program. The patient must be kept as happy and as occupied as his condition warrants and as a safeguard for his emotional and physical recovery.

A well-equipped library is essential. Motion pictures and radio provide excellent media for entertainment.

The choosing of new occupations for those

* Read before the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.

From State Bureau of Rehabilitation.

Copy of complete paper may be secured from California Tuberculosis Association.

* Read before the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.

From Jewish Consumptive Relief Association, Los Angeles, California.

Copy of complete paper may be secured from California Tuberculosis Association.

who cannot return to their former work, and the training for those positions, is an important part of sanatorium care.

School work must be arranged for those in need of it and this is provided through the sanatorium classes.

Medical supervision as well as a continued social service program after the patient leaves the sanatorium is one of the requisites.

Assistance to the family, to save the patient from worry, is vital.

From the time of admission to the departure of the patient and for as long after his dismissal as he needs such help, the social service program is a coöperative effort of doctors, nurses, social worker, teachers, and occupational directors.

TEACHING TEACHERS TO TEACH HEALTH*

JOHN L. C. GOFFIN, M.D.
Los Angeles

A MODERN school health education program is one in which the school assumes responsibility for healthy children, educated in healthful ways of living in a healthful school environment.

Teachers are the chief medium for health education of the child. In their efforts to educate the whole child, body, mind, and spirit, they are constantly balked by health problems. The teacher takes these problems to the school physician for adjustment. The school nurse aids the physician and the home in getting these health problems solved, and physician and nurse help train the teacher to prevent pupil maladjustments by sound health education.

In the modern school everybody has a hand in this program and agencies outside the school may play their part. Without community participation, no school health program can be fully successful.

Tuberculosis Association workers specialize in fighting the tubercle bacillus, but its allies—ignorance, quackery, poverty, overcrowding, poor sanitation, malnutrition, chronic infection, and alcoholism—must be conquered also. This fight takes the Tuberculosis Association into the field of school health education. These workers can help to strengthen the school health program and aid in the task of teaching teachers to teach health.

In participating effectively in the health program in schools, it is essential to know the local situation and the community health problems. When these problems are understood, it is essential to know what the schools of the community are doing to help solve them. This involves getting acquainted with the school personnel from the Superintendent down, especially the school health workers.

In offering to strengthen the school health education program a constructively helpful approach

is essential rather than a negatively critical attitude or one which offers panaceas or overnight reorganization. The case-finding survey, if one has not been organized, offers an excellent opportunity to make a health education contribution. There are many other tools at your disposal: posters, talks, motion pictures, health education units, pamphlets, etc.

Probably the most effective effort is one in which the schools, the local health department and the local tuberculosis association join as a co-operative enterprise.

ORGANIZATION PROBLEMS*

DALRIE S. LICHTENSTIGER
Martinez

A SUMMARIZATION is given of the problems of a tuberculosis organization and suggests procedures. The question of what constitutes a "good" organization, how a volunteer organization may be made to run smoothly, who should make up the board of directors, how to organize and carry out a program, are all discussed.

The paper is essentially one for full-time association secretaries, but contains material which would be of help even to those associations which do not employ such secretaries.

The tuberculosis mortality rate is now approximately 47 per 100,000 of the population. In the early 1900's it was close to 200.

Thirty years ago tuberculosis was responsible for 11 out of every 100 deaths occurring in the United States. Today it is responsible for less than five out of every 100 deaths.

Today tuberculosis is responsible for the death of one individual every eight and one-half minutes. Thirty years ago deaths occurred at the rate of one every three and one-half minutes.

There are more than 90,000 beds for the treatment of tuberculosis in the United States.

There are estimated to be about 500,000 active cases of tuberculosis in the United States.

During the period from 1937 to 1940 tuberculosis killed more Americans than were killed in action, or died from wounds received in action, during all the wars the United States has fought since 1776. The menace of tuberculosis is steadily reduced each year by Christmas Seal funds.

China held its first Christmas Seal sale in 1938 in the midst of war with Japan and has continued to hold a seal sale each year.

* Read before the California Tuberculosis Association, Los Angeles, April 11, 1942.
Abstract.

From Board of Education, Los Angeles.
Copy of complete paper may be secured from California Tuberculosis Association.

* Read before the California Tuberculosis Association, Los Angeles, April 9, 1942.
Abstract.

From Contra Costa Public Health Association, Martinez, California.
Complete copy of paper may be secured from California Tuberculosis Association.

THE TUBERCULOSIS ORGANIZATIONS IN AMERICA

Organized in 1904, the aims of the National Tuberculosis Association are: *To study tuberculosis in all its forms, spread knowledge as to its causes, treatment and prevention.* Carried on through 48 state organizations, 2000 local associations, 700 hospitals and sanatoria, 1000 tuberculosis clinics, 23,000 public health nurses, thousands of physicians, and many other volunteers, the work is financed by the annual sale of Christmas Seals, which in 1941 provided more than seven million dollars. (The 1942 Christmas Seal is designed by Dale Nichols, Tucson, Arizona.

The Seals go on sale November 23.)

In 1889, when Dr. Hermann M. Biggs asked twenty-four of New York's leading physicians how they felt about having the Board of Health warn people against tuberculosis as infectious and preventable, and issue regulations for public protection, only two replied favorably. Today, physicians in general practice, throughout the country are whole-heartedly coöperating in tuberculosis control work. In California they are a motivating power behind the work of the tuberculosis associations.

* * *

NATIONAL TUBERCULOSIS ASSOCIATION

1790 Broadway, New York City

Officers

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* * *

AMERICAN TRUDEAU SOCIETY

(Clinical Section of National Tuberculosis Association)

Officers

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H. FRANK CARMAN, M. D., Dallas, Texas, *Vice-President*

JULIUS L. WILSON, M. D., New Orleans, La., *Secretary-Treasurer*

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CALIFORNIA TUBERCULOSIS ASSOCIATION

45 Second Street, San Francisco

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R. H. SUNDBERG, M. D., San Diego
HAROLD G. TRIMBLE, M. D., Oakland
HARRY C. WARREN, M. D., Belmont

* * *

CALIFORNIA TRUDEAU SOCIETY

(Clinical Section of California Tuberculosis Association)

Officers

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HOWARD W. BOSWORTH, M. D., Los Angeles, *President-Elect.*

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EMIL BOGEN, M. D., Olive View, *Secretary-Treasurer*

CALIFORNIA TUBERCULOSIS ASSOCIATION

A Federation of 62 Local Associations

ROSTER OF MEMBER ASSOCIATIONS

<i>Alameda County Tuberculosis and Health Association</i> 121 East 11th Street, Oakland Carlisle Crosby, President E. P. Von Allmen, Executive Secretary	<i>Madera County Tuberculosis Association</i> Madera Howard L. Rowe, President	<i>San Francisco Tuberculosis Association</i> 604 Mission Street, San Francisco Easton G. Hecker, President Paul Nelman, Executive Secretary
<i>Alpine County Tuberculosis Association</i> Markleeville Mrs. Eugenia Bruns, President	<i>Marin County Tuberculosis Association</i> San Rafael Mrs. Herbert Chamberlain, President	<i>San Diego Tuberculosis Association</i> 1266 Seventh Avenue, San Diego Mrs. Francis H. Mead, President Mrs. Elizabeth G. Cary, Executive Secretary
<i>Amador County Tuberculosis Association</i> Jackson Ralph McGee, President	<i>Mariposa County Tuberculosis Association</i> Mariposa Judge Andrew R. Schottky, President	<i>San Joaquin County Tuberculosis Fund</i> 130 South American Street, Stockton Mrs. Percy C. Cleghorn, President Miss Bernice Frankenheimer, Executive Secretary
<i>Butte County Tuberculosis and Health Association</i> Biggs Dr. Edwin S. Peeke, President	<i>Mendocino County Tuberculosis Association</i> Ukiah Mrs. Mark Eglin, President	<i>San Luis Obispo County Tuberculosis Association</i> 411 16th Street, Paso Robles Mrs. A. S. Young, President
<i>Calaveras County Tuberculosis Association</i> Murphys Dr. Elliott P. Smart, President	<i>Merced County Tuberculosis Association</i> Merced Hugh K. Landrum, President	<i>San Mateo County Tuberculosis and Health Association</i> 115 Ellsworth Avenue, San Mateo Bradford M. Melvin, President Mrs. Ruth Close, Executive Secretary
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<i>El Dorado County Tuberculosis Association</i> Placerville Dr. A. A. McKinnon, President	<i>Napa County Tuberculosis Association</i> Napa Mrs. Edgar D. Wallace, President Mrs. Jane Boggs, Executive Secretary	<i>Siskiyou County Tuberculosis Association</i> Yreka O. G. Steele, President
<i>Fresno County Tuberculosis Association</i> Fresno Dr. Clairmont P. Doane, President Frank Harader, Executive Secretary	<i>Nevada County Tuberculosis Association</i> Nevada City John Mann, President	<i>Solano County Tuberculosis Association</i> 526 Carolina Street, Vallejo Dr. Gordon J. Bunney, President Mrs. Dairie Lichtenstiger, Executive Secretary
<i>Glenn County Tuberculosis Association</i> Willows A. D. Pieper, President	<i>Orange County Tuberculosis and Health Association, Ltd.</i> 112 West Fifth Street, Santa Ana Mrs. Oliver Wickersham, President Mrs. Edna H. Crawford, Executive Secretary	<i>Sonoma County Tuberculosis Association</i> 618 Fourth Street, Santa Rosa Dr. C. M. Carlson, President William M. Flaherty, Executive Secretary
<i>Humboldt County Tuberculosis Association</i> Eureka Dr. Joseph Woolford, President Mrs. Claude Morrow, Executive Secretary	<i>Pasadena Tuberculosis Association</i> 245 South Lake Avenue, Pasadena Mrs. H. Page Warden, President Miss Alice R. Kratka, Executive Secretary	<i>South Pasadena Tuberculosis Association</i> 1132 Mission Street, South Pasadena Mrs. Jole Tunison, President
<i>Imperial County Tuberculosis and Health Association</i> El Centro Paul W. Cook, President	<i>Placer County Tuberculosis Association</i> Auburn Mrs. Pierre Goss, President	<i>Stanislaus County Tuberculosis and Health Association</i> Turlock C. F. Perrott, President
<i>Inyo County Tuberculosis Association</i> Lone Pine Mrs. M. L. Harbach, President	<i>Plumas County Tuberculosis Association</i> Quincy Frank McAuliffe, President	<i>Sutter County Tuberculosis Association</i> Yuba City A. A. McMullen, President
<i>Kern County Tuberculosis Association</i> 1825 "H" Street Bakersfield O. R. Kamprath, President Miss Constance Poss, Executive Secretary	<i>Riverside County Health and Tuberculosis Association</i> Riverside Ernest G. Button, President Mrs. Louise Phillips, Executive Secretary	<i>Tehama County Tuberculosis Association</i> Red Bluff Bert Storm, President
<i>Kings County Tuberculosis Association</i> Hanford F. J. Bowden, President	<i>Sacramento County Tuberculosis Association</i> 1006 Seventh Street, Sacramento Fontaine Johnson, President Mrs. Estella S. Edson, Executive Secretary	<i>Trinity County Tuberculosis Association</i> Weaverville Dr. L. C. Moore, President
<i>Lake County Tuberculosis Association</i> Lakeport W. Roland Hanson, President	<i>San Benito County Tuberculosis Association</i> Hollister Eleanor Nolan, President	<i>Tulare County Tuberculosis Association</i> Lindsay Marc H. Iseman, President
<i>Lassen County Tuberculosis Association</i> Susanville Dr. J. W. Crever, President	<i>San Bernardino County Tuberculosis Association</i> 490 Court Street, San Bernardino L. E. Mitchell, President Stanley T. Boggess, Executive Secretary	<i>Tuolumne County Tuberculosis Association</i> Sonora Ben Johnson, President
<i>Long Beach Tuberculosis Association</i> 921 Pacific Avenue Long Beach E. E. Buffum, President Miss Annis L. Fletcher, Executive Secretary	<i>Santa Barbara County Tuberculosis and Health Association</i> Court House, Santa Barbara Frank J. McCoy, President Graydon Dorsch, Executive Secretary	<i>Ventura County Tuberculosis Association</i> Santa Paula Mrs. Roger Edwards, President
<i>Los Angeles Tuberculosis and Health Association</i> 1010 Transportation Building, 122 East 7th Street, Los Angeles Dr. Howard W. Bosworth, President James G. Stone, Executive Secretary	<i>Santa Clara County Tuberculosis Association</i> 409 Beans Building, San Jose Dr. O. N. Andersen, President Mrs. Ann Castellanos, Executive Secretary	<i>Yolo County Tuberculosis Association</i> Woodland Mrs. D. W. McWilliam, President
<i>Los Angeles County Tuberculosis and Health Association</i> 132 West First Street, Los Angeles Bernard C. Brennan, President Miss Josephine McCarty, Executive Secretary		<i>Yuba County Tuberculosis Association</i> Marysville Dr. J. W. Linstrum, President

(Continued from Page 18)

The method about to be described is simple, inexpensive and efficient; so simple, in fact, that the same idea must have occurred to others. But there are still those who occasionally find themselves in the embarrassing position of not having enough hands for the many tasks which arise during the course of an intravenous anesthetic, and it is for these that this suggestion is intended.

Four strips of adhesive are prepared before the anesthetic is begun; one strip about 2" x 18", and the other three about 1" x 6". The first strip firmly binds the patient's arm to the arm-board, and is placed over the wrist so that both flexion and rotary motion of the arm is impossible. After the initial injection is made, a second strip is placed over the hub of the needle to anchor it in place. The third strip is placed along the barrel and plunger of the syringe, to prevent blood from backing up into the solution. The syringe is then elevated, to produce the correct amount of angulation, and supported with a sponge, and the fourth strip of adhesive then binds the barrel of the syringe to the patient's arm.

In this way the syringe is bound firmly to the patient's arm, and the anesthetist can safely leave the syringe from time to time to regulate the patient's airway, administer oxygen if necessary, observe the vital signs and refill his own syringes. The adhesive strip running along the plunger of the syringe can be easily lifted and replaced for injections.

1401 So. Hope Street.

A Surgeon's Prayer in Wartime

God of Battle, grant that the wounded may swiftly arrive at their hospital haven, so that the safeguards of modern surgery may surround them, to the end that their pain is assuaged and their broken bodies are mended.

Grant me as a surgeon, gentle skill and intelligent foresight to bar the path to such sordid enemies as shock, hemorrhage and infection.

Give me plentifully of the blood of their non-combatant fellow man, so that their vital fluid may be replaced and thus make all the donor people realize that they, too, have given their life's blood in a noble cause.

Give me the instruments of my calling so that my work may be swift and accurate; but provide me with resourceful ingenuity so that I may do without bounteous supplies.

Strengthen my hand, endow me with valiant energy to go on through day and night; and keep my heart and brain attuned to duty and great opportunity.

Let me never forget that a life or a limb is in my keeping and do not let my judgment falter.

Enable me to give renewed courage and hope to the living and comfort to the dying.

Let me never forget that in the battles to be won, I too must play my part, to the glory of a great calling and as a follower of the Great Physician. Amen.

Christmas night, 1941.

John J. Moorhead, Col., M.C., in Hawaii M.J.

1:157 (January) 1942.

Diagnosis is to disease what harmony is to music: any discord is fatal.

When the proper technique is patiently pursued the diagnosis makes itself.

Without a correct diagnosis, therapy is blind and often harmful.

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CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section, on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

WILLIAM R. MOLONY, SR., M.D.....President
KARL L. SCHAUPP, M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON.....Executive Secretary

EDITORIAL BOARD

Chairman of the Board:

Dwight L. Wilbur, San Francisco.

Executive Committee:

Dwight L. Wilbur, San Francisco, Chm.
Fred D. Heegler, Napa.
Albert J. Scholl, Los Angeles.
George W. Walker, Fresno.

Anesthesiology:

Charles F. McCuskey, Glendale.
H. R. Hathaway, San Francisco.

Dermatology and Syphilology:

H. J. Templeton, Oakland.
William H. Goeckerman, Los Angeles.

Eye, Ear, Nose and Throat:

Frederick C. Cordes, San Francisco.
L. G. Hunnicutt, Pasadena.
George W. Walker, Fresno.

General Medicine:

Garnett Cheney, San Francisco.
George H. Houck, Los Angeles.
Mast Wolfson, Monterey.

General Surgery (including Orthopedics):

Frederick C. Bost, San Francisco.
Clarence J. Berne, Los Angeles.
Fred D. Heegler, Napa.

Industrial Medicine and Surgery:

John E. Kirkpatrick, Shasta Dam.
John D. Gillis, Los Angeles.

Plastic Surgery:

George W. Pierce, San Francisco.
William S. Kiskadden, Los Angeles.

Neuropsychiatry:

John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

Obstetrics and Gynecology:

Erle Henriksen, Los Angeles.
Daniel G. Morton, San Francisco.

Pediatrics:

William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:

David A. Wood, San Francisco.
R. J. Pickard, San Diego.

Radiology:

R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:

Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:

Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

HOUSE OF DELEGATES: FIRST MEETING Minutes of the Thirty-Ninth Annual Session of the House of Delegates of the California Medical Association

*Held at Hotel Del Monte, Del Monte, California
Monday, May 4, and Wednesday, May 6, 1942*

**First Meeting, Monday Evening, May 4, 1942, in
Room E, Convention Pavilion, Hotel Del Monte**

The first meeting of the House of Delegates of the California Medical Association, at the seventy-first annual session, held in Hotel Del Monte, Del Monte, California, was called to order at 8:30 p.m., Speaker Lowell S. Goin, presiding.

1 1 1

SPEAKER GOIN: The House will be in order. The first order of business is the temporary report of the Credentials Committee (Edmund P. Halley, of Stockton; William M. Miller, of Auburn; and Delbert B. Williams, of San Bernardino). The Chair recognizes the Chairman of that Committee, Doctor Halley of San Joaquin.

DOCTOR HALLEY: Mr. Speaker, the Committee begs to report that there are 104 delegates. I move that they be seated.

SPEAKER GOIN: It has been moved by the Chairman of the Committee, and seconded by Doctor Doughty, that these delegates be seated. All in favor say, "Aye"; contrary, "No." The motion is carried.

SPEAKER GOIN: Mr. Secretary, is there a quorum present?

SECRETARY KRESS: Mr. Speaker, a quorum is present.

SPEAKER GOIN: A quorum being present, and the provisions of the constitution and by-laws having been complied with, I declare this House of Delegates duly constituted and open for the transaction of such business as may come before it.

The first order of business is the announcement of the committees—the Reference Committees of the House. The Chair has appointed the following:

REFERENCE COMMITTEE No. 1: *The Committee on the Report of the Officers and Standing Committees:*

J. Norman O'Neill, of Los Angeles, Chairman.
William A. Keene, of San Mateo.
H. D. Hoffman, of Orange.

REFERENCE COMMITTEE No. 2: *The Committee on the Report of the Council, Secretary-Treasurer, and Executive Secretary:*

L. Henry Garland, of San Francisco, Chairman.
W. L. Garth, of San Diego.
Charles F. Greenwood, of Alameda.

REFERENCE COMMITTEE No. 3: *The Committee on Resolutions and Amendments to the Constitution and the By-laws, and New and Miscellaneous Business:*

Dwight L. Wilbur, of San Francisco, Chairman.
Dwight Murray, of Napa County.
Donald G. Tollefson, of Los Angeles.

The next order of business is the address of the President, and I have the honor of presenting to you the President of this Association, Dr. Henry S. Rogers, of Petaluma.

† For complete roster of officers, see advertising pages 2, 4, and 6.

Address of President Rogers

PRESIDENT ROGERS: Mr. Speaker and Members of the House of Delegates: This morning I made in my address a casual reference to some of the political trends that may affect you in the future. As you will recall in the President's message to Congress, he cited that there would be an increase in the payroll tax to provide for the disability unemployment insurance to workers. Also hospital benefits. Since that time, on an average of about every five days, there has been appearing in the financial sheets, the *Wall Street Journal* particularly, about four inches in a column that is almost identical, word for word with each issue that comes out; except one issue will be the Department of Labor, the next time the Treasury Department, and another time the Social Security Board. Then it starts all over again with the Department of Labor all calling for an increase in payroll tax for Social Security, disability and unemployment and hospital benefits. The report of the Social Security Board, released about a month ago to Congress, goes a little bit farther. It expresses a wish to Congress for a 1 per cent payroll deduction, and provides the same rate of pay for disability and unemployment insurance that is now paid for our unemployment insurance. In addition to this, hospitalization for sickness, and a bonus of \$3.00 per day while the individual is confined to the hospital are suggested. This is an attempt at the first step towards governmental control of medical care. If this goes through and is accepted, then in another year, a year and a half, or two years, there would be another request preceded by months of newspaper bombardment for another payroll tax to provide medical care for all the workers.

Now the only way that I can see for the medical profession to combat this is by unity and solidarity in our medical societies, so that we can present a unified front to the politicians. California Physicians' Service has definitely shown us a lot the necessity of medical care for these groups of citizens, on a prepayment basis. As far as the public is concerned, the people must be sold to the plan; they don't ask for it. It isn't the public that is asking the government to step in to give them this health insurance; it is the social service workers, plus the politicians, who see in this an opportunity to get their hands on payroll deductions, so they can sit around in sumptuous offices and manage the plan. I am hoping tonight, in all your deliberations that you keep in mind the relationship that the medical profession owes to the general public—our place in life in this country. Let us hold together in one solid unit and continue as a strong California Medical Association. (Applause.)

SPEAKER GOIN: Thank you, Doctor Rogers. The report of the Council will now be given to you by its Chairman, Philip K. Gilman, Captain United States Navy.

* * *

Supplementary Report of Council

DOCTOR GILMAN: Mr. Speaker, in addition to the report of the Council printed in the *Pre-Convention Bulletin*, there are a few additions I wish to make.

1 1 1

New Item No. 1.—Regarding Alameda County Medical Association and California Physicians' Service:

WHEREAS, The Council of the Alameda County Medical Association has by resolution advised the members of said Association to resign as professional members of the California Physicians' Service; and

WHEREAS, The Council of the California Medical Association, at its meeting held May 3, 1942, duly resolved to present to the Alameda County Medical Association

the following question: "Will the members of the Council of the Alameda County Medical Association on behalf of its membership for the benefit of medicine and for the good of the profession in California, subjugate their personal opinions to the opinion of the majority of their fellows of the California Medical Association and rescind the resolution above mentioned; now, therefore, be it

Resolved, That the answer of the Council of the Alameda County Medical Association to said questions may be deferred for a period of thirty days. And within that time the Alameda County Medical Association must submit a definite answer in writing to the foregoing questions submitted to it.

1 1 1

New Item No. 2.—Regarding Unit Values in Medical Service Plans:

A Committee of the Council is studying the question of hospital costs, and it is believed that certain changes can be made which will result in raising the unit values of the California Physicians' Service.

SPEAKER GOIN: Thank you, Doctor Gilman. The report of the President will be referred to Reference Committee No. 1. The Council report will be referred to Committee No. 2.

1 1 1

OTHER REPORTS

The next report is a report of the *Trustees of the California Medical Association*.

DOCTOR GILMAN: The report has been printed in the *Pre-Convention Bulletin*, Mr. Speaker, and needs no further additions.

SPEAKER GOIN: The report is referred to Reference Committee No. 1. The next order of business is the report of the *Auditing Committee*, Doctor John Cline, Chairman.

DOCTOR CLINE: The report has been printed in the *Pre-Convention Bulletin* and there are no additions.

SPEAKER GOIN: This report will be referred to Reference Committee No. 1. The next will be a report of the *Secretary-Treasurer*, Doctor Kress.

SECRETARY KRESS: The report has been printed in the *Pre-Convention Bulletin*. No additional report.

SPEAKER GOIN: This will be referred to Reference Committee No. 2. The next is the report of the *Executive-Secretary*, Mr. John Hunton.

MR. HUNTON: No additional report.

SPEAKER GOIN: Referred to Reference Committee No. 2. Report of the Editor, Doctor Kress.

SECRETARY KRESS: No additional report.

SPEAKER GOIN: Referred to Reference Committee No. 1.

(Vice-Speaker Askey takes the chair.)

1 1 1

VICE-SPEAKER ASKEY: The next is a report of the Chairman of the *Department of Public Relations*, Doctor Donald Cass, Chairman.

DOCTOR CASS: No further report.

VICE-SPEAKER ASKEY: The report will be referred to Reference Committee No. 1. We will now hear a report from our General Counsel, Mr. Hartley F. Peart.

MR. PEART: The report of the *Legal Department* is printed in the *Pre-Convention Bulletin*, and I will not burden you with any of the matters that it contains. I do, however, desire to call your attention and briefly discuss some vital developments in the field of government which have crept upon us in the past few years and which, if not properly understood, may engulf the profession.*

* Mr. Peart's Report appears in this issue, as one of the General Articles. See page 112.

VICE-SPEAKER ASKEY: You have heard the report of our Counsel, Mr. Peart. This report will be referred to Reference Committee No. 1. The next order of business is taking up of the *Reports of our Standing and Special Committees*. All these reports have been published in our Pre-Convention Bulletin. As I call the names of the Chairmen of each committee he may report a supplementary report if he has one. . . .

NOTE. Chairmen or Members of the Standing and Special Committees listed below stated they desired to make no additions to their respective reports, as printed in the *Pre-Convention Bulletin*.

* * *

Reports of Standing Committees:

A. Standing Committees.

- Executive Committee—Henry S. Rogers.
- Committee on Associated Societies and Technical Groups—John V. Barrow.
- Committee on Audits—John W. Cline.
- Committee on Health and Public Instruction—John Ruddock.
- Committee on History and Obituaries—Morton R. Gibbons, Sr.
- Committee on Hospitals, Dispensaries, and Clinics—J. Norman O'Neill.
- Committee on Industrial Practice—Donald Cass.
- Committee on Medical Defense—Nelson Howard.
- Committee on Medical Economics—Glenn Cushman.
- Committee on Medical Education and Medical Institutions—Loren R. Chandler.
- Committee on Membership and Organization—L. A. Alesen.
- Committee on Postgraduate Activities—Dwight L. Wilbur.
- Committee on Publications—A. A. Alexander (Deceased.)
- Committee on Public Policy and Legislation—Dwight H. Murray.
- Committee on Scientific Work—George H. Kress.
- Committee on Public Relations—Donald Cass.
- Cancer Commission—Otto Pflueger.

Reports of Special Committees:

B. Special Committees.

- Committee on Payments for Medical Services—John W. Green.
- Committee to Survey California Medical Association Legal Department—Philip K. Gilman.
- Committee on Conference with California State Federation of Labor—John W. Cline.
- Committee on Medical Services Rendered by Hospital Associations—Dewey R. Powell.
- Committee on Pension Policy for Retired Employees—Edward N. Ewer.
- Committee on Hospitalization Subsidy—John H. Shephard.
- Committee on California Industrial Accident Commission Fee Schedules—Morton R. Gibbons, Sr.
- Committee on Medical Preparedness—Harold A. Fletcher.

* * *

VICE-SPEAKER ASKEY: The report of the *Committee on Public Policy and Legislation*, Doctor Murray.

DOCTOR MURRAY: No further report, Mr. Chairman.

SPEAKER GOIN: I think that this House ought to hear Doctor Murray.

Report: Committee on Public Policy and Legislation

DOCTOR MURRAY: Members of the House of Delegates: If you were present this morning you heard some of the things I had to say with reference to some of the work that has been done. If you have time, or will have time, or care to read, look at the report in the Pre-Convention Bulletin. You will find there the happenings that have taken place since this time last year. First of all, it was the end of the legislation session last year. The session was a bit stormy. That is past history. You probably know all the things that happened. The bills we considered most important were enacted. There were one or two bills that we would like to have seen passed, that were not enacted. However, there were no proposed laws enacted that we considered destructive or dangerous. . . .

Now the thing that may come to us, is State Medicine. That is the thing you have been hearing about all day and the thing that you will be hearing about all during the sessions of this meeting. We were told at Sacramento, in 1939, in no indefinite terms that, if there was not some plan evolved by which the low-income citizens of the State of California could have medical care, if we didn't provide it, we could expect that somebody else would provide it for us, and that somebody else of course would be through a government-controlled affair. It was then that California Physicians' Service was brought into being, and that has answered our problem so far. Last year at the beginning of the legislature, our friends in the legislature told us, "If you don't do something about this, we will certainly not stand by you anymore." We were asked very definitely and very particularly about C.P.S., and we had to give the Legislators our word of honor, individually and collectively, and we had to tell them that it was the truth, because it was. We have given them our word of honor that we are going to see this thing through, and believe me, we can't stop in the middle of the stream. If we do, we are just sunk, and that's all there is to that. . . .

The Legislators never forget a promise that is made, and if ever you tell them one thing they will never forget it. We must keep our promise, and I hope nothing will be done to destroy the service and other value of California Physicians' Service. . . .

Now you may be expected to be called upon a good many times, even you may think we have called upon you a lot in the past. Well, you are going to be called on a lot more in the future. I wish to thank you all for the assistance you have given us. Remember, when you sent me up to Sacramento last year, I told you I thought I had never seen such a big pair of shoes as June Harris wore. Now I am asking, since you sent me up there, do not throw me down, do not throw your committee down. Help us and we shall try to help you. Thank you very much.

VICE-SPEAKER ASKEY: Doctor Murray says he wants to thank us. I think this House of Delegates owes a vote of thanks to Doctor Murray. (A rising vote of thanks was given Doctor Murray.)

VICE-SPEAKER ASKEY: You see, Doctor Murray, we do appreciate you. We are going to stand back of you. Doctor Murray's report will be referred to Reference Committee No. 1. The Committee on Scientific Work and Annual Session Programs, Doctor George H. Kress.

SECRETARY KRESS: No further report.

VICE-SPEAKER ASKEY: The next is the report of the *Committee on Medical Benevolence*, Doctor Axel Anderson, Chairman. Dr. Anderson is ill and unable to be here. Our President, Doctor Rogers, will say a word about this.

PRESIDENT ROGERS: Mr. Speaker, I think if Doctor Anderson were here this evening he would have a supplementary report to add to his printed report.

This morning, at the general session, Mrs. Harry Hund, the President of the Woman's Auxiliary, presented to this committee, or to the C.M.A. for this committee, the sum of \$734.00 from the Woman's Auxiliary, to be applied to the Benevolence Fund. (Applause.)

SECRETARY KRESS: Mr. Speaker, Doctor Anderson has submitted a supplementary report.

VICE-SPEAKER ASKEY: If it is the wish of this House, the supplementary report will be included in the report. Hearing no objection, it is included and is referred with the rest of the report to Reference Committee No. 3.

We have other special committees, the *Committee on Payment for Medical Services*, Doctor John W. Green, Chairman.

DOCTOR GREEN: Mr. Speaker, the report of this committee has been filed. Would you like to have a report made, Vice-Speaker Askey?

VICE-SPEAKER ASKEY: Has it been published, Doctor Green?

DOCTOR GREEN: No, it has not been published, but it has been filed.

VICE-SPEAKER ASKEY: Will you please read it?

Report: Committee on Payments for Medical Services

DOCTOR GREEN: The report of this committee was presented subsequent to the House of Delegates' Resolution No. 12 of the last session and there was considerable correspondence considering this. There were a lot of complaints throughout the State of low pay for medical services, particularly that part which applied to large practice, so this was given to our committee. I don't believe that I should read all the correspondence. . . .

The other members of the committee thought there were certain legal aspects to this whole problem, and in order to get an answer for it, that we should appeal to Legal Counsel Peart, which we did. We have here his reply. I hate to read this because I am not a lawyer, I get all tangled up when I even think about it. . . .

"Dear Doctor: Since I wrote my letter to you of October 6th, 1941, we have had an opportunity to further study your inquiry concerning a possible by-law amendment under which the membership in the Association would be forfeited by any member who rendered professional services for fees below the standard adopted by the Association. We are discussing each point which appears to be relevant separately:

First, Expulsion Procedure.

As you no doubt understand, a member of a component county medical society or the California Medical Association may not be expelled from membership because of any act or conduct on his part unless due process of law is followed. This means that any member against whom charges are made must be furnished a complete copy of the charges, must be given due notice, and be given a full opportunity to be heard, and must not be expelled or otherwise disciplined unless the evidence is produced at an open hearing establishing violation of some constitutional or by-law provision or some accepted rule of professional conduct. Of course, the disciplinary provisions contained in the present laws of the California Medical Association comply with the foregoing requirements and were prepared and adopted by the Association in order that proper rules of procedure may exist for any disciplinary proceeding. The method set forth in the Disciplinary Code, Chapter II of the by-laws, is the only method that may be followed.

Two, the Adoption of a Minimum Fee Schedule. As we understand it, your proposal that a minimum fee schedule be adopted, first, through a by-law provision; and that any member who renders service below such a fee schedule shall be liable to expulsion or other discipline. Normally, courts do not interfere with the internal affairs of any incorporated association or society. However, there are certain cases expressly holding that any by-laws or any other rule of any association or society which is arbitrary or unreasonable may not be enforced and may not be the basis for expulsion. We have only been able to find one case directly dealing with the by-law provision of a medical society under which fees were regulated. The case in question is "The People vs. Erie County Medical Society," where it was held that a rule of the Erie County Medical Society fixing the minimum fee was unreasonable and against public policy. In that case, a member of the Erie County Society was expelled on the grounds that he did not live up to the Fee Schedule, and upon other grounds. The court held that the society had no right to interfere with the relationship of the member and his patient to the extent of dictating the fee to be charged. The Erie County Medical Society case arose in New York and was decided many years ago. However, we have been unable to discover any recent case directly in the point.

There is one case recently arising in the State of Washington which, while not exactly at point, is of some help. The case is "Horder vs. the King County Medical Society" where it was held that a county society by-law forbidding members to participate in a closed staff clinic or group practice was held valid and enforceable. The Supreme Court of the State of Washington stated that in its opinion the motive of the county society in adopting the by-law amendment was immaterial—and even assuming a selfish motive—such fact did not justify judicial interference.

There are no California cases directly on this subject. In view of the New York case above discussed, it is our opinion that it would be very unwise for the Association to undertake and adopt and enforce a minimum Fee Schedule even though the general views expressed in the Washington case might be used as an argument to support such a by-law provision.

Three, Present Rules of Professional Conduct. This is quite important. The principles of medical ethics of the American Medical Association at the present time provide that a physician shall not engage in the type of practice which results in inadequate or incomplete medical care. The principles also forbid the physician to dispose of his services under conditions interfering with reasonable competition among and with the physicians of the community. (Principles of Medical Ethics, Article 6, Section 2.) It seems to us that the type of practice which you have in mind, more than likely violates the foregoing sections of the principles of medical ethics. If this is so, it is not necessary to have a new by-law provision as a disciplinary proceeding should be based upon the existing principles. If there are any further inquiries that I have not fully answered, please let me know."

The report of the Special C.M.A. Committee is this: An exchange of our ideas on this subject came through correspondence with Doctor Best, Doctor E. R. Moody, Doctor A. E. Anderson, Mr. Hartley F. Peart, and after reading the letter of Mr. Peart which is appended, concerning this practice and proposed amendments to the by-laws, we have to report that no amendment will be suggested; Mr. Peart having informed us that such could not lawfully be done. (Applause.)

VICE-SPEAKER ASKEY: Thank you, Doctor Green, the report of this committee will be referred to Reference

Committee No. 3. Another special committee is that of the *Committee to Survey the California Medical Association Legal Department*, Doctor Philip Gilman, Chairman.

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DOCTOR GILMAN: Mr. Speaker, Doctor Best was Chairman of this committee, and when he was sent overseas I was requested to take his place as Chairman of that committee. The report of this committee, which is the result of a considerable amount of work, has been filed and is ready for your action.

VICE-SPEAKER ASKEY: The report of this committee will be referred to Reference Committee No. 3. The *Committee on the Conference with the California State Federation of Labor*, Doctor John Cline, Chairman.

Report: Conference with California State Federation of Labor

DOCTOR CLINE: Mr. President, Mr. Speaker, and Members of the House of Delegates: This is in the nature of a progress report and is not in its final form. The Committee came into being as a result of certain overtures made to the California Medical Association by the California Federation of Labor. They never reduced to writing a desire to meet with us, but communicated by way of one of the members of the California Medical Association, whose offices are next door to the California Federation offices in San Francisco. A minority meeting of the council was held along with certain other members of the Association, in the Association offices, and a discussion was held concerning the points that the California Federation wished to discuss. Their first desire was that the California Medical Association set up a panel of industrial surgeons. It was pointed out to their medical spokesman at that time that that was an impossible thing for us to do. We pointed out to them that every doctor licensed in the State of California was competent and legally able to perform any service in industrial medicine and surgery, and that industrial medicine and surgery differed in no degree except that someone else was responsible for the care of such patients from the ordinary practice of medicine and surgery, and that the only method that we could pursue would be to send out to all members of the California Medical Association a blank asking whether or not they wished to take care of industrial patients.

That seemed to be unacceptable to the representatives of the California Federation, and they proposed then that we endorse a program whereby the two universities in the South and the two in the North set up panels. We pointed out again that that was something they would have to take up with the universities and had nothing whatsoever to do with the California Medical Association. Following came a series of meetings, and a committee was appointed. This committee was to continue negotiations with the California Federation of Labor in an effort to ascertain just what the Federation wanted. The Secretary of the California Federation of Labor, Mr. Vandeleur, was represented in some of these meetings by his attorney, Mr. Jennigen. . . . The Federation desired what we have expressed in this House of Delegates in the past, but there were certain implications concerning which I think the C.M.A. House of Delegates should be informed. Namely, in the first instance, free choice of physician. Now that is a fixed principle as far as our Society is concerned. On the other hand, the implication which we were able to obtain from the representatives of the California Federation was that, in the event of free choice in the case of destruction of the current principle that the insurance company has a voice in the direction of patients, that they would then set up of their own motion, certain panels of individuals to whom the patients would be sent. Further inquiry

into that revealed that their desire was two-fold. . . . So when we reached that juncture, negotiations became rather difficult and at that point, Doctor Murray, Chairman of the Legislative Committee and President Rogers, both of whom had much closer contact with the individuals involved, took over, and at the present moment they are continuing negotiations with the California Federation of Labor in the effort to obtain a program which will be mutually acceptable to the California Federation of Labor and to the California Medical Association; and one which, at any rate, we should not feel compelled to oppose should it reach the Legislature, and one that we would prefer to give our whole-hearted support to, and also which would abolish the abuses which are fairly legitimate. (Referred to Committee No. 3.)

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Report: Committee on Medical Services Rendered by Hospital Associations

Next is the report of the *Committee on Medical Services Rendered by Hospital Associations*, Doctor Dewey Powell, Chairman.

DOCTOR POWELL: Mr. Speaker, Members of the House: Your committee on Medical Services rendered by Hospital Associations makes the following report. We recommend that a statement of policy adopted by the Council of the California Medical Association on October 26, 1941, be reiterated at this time and officially adopted by this House. That report is summarized in the following paragraph:

"California Medical Association has consistently endorsed the principle of hospital service insurance and, upon request, the Council of the California Medical Association has given its approval to some or all of the activities of local hospitalization associations. The California Medical Association recommends only those hospital contracts which provide straight hospital services. It does not give, and it never has given approval to any contracts which provide medical benefits or services as a part of hospital services. It does not object to the provisions of limited diagnostic medical services, such as x-ray and laboratory along with hospital benefits, provided that these are arranged for on some ethical and legal basis, such as reimbursement indemnification. The Committee further recommends that the Council of the Society use every effort to see that this policy is carried out by the hospital associations in this state, both in spirit and in letter."

Mr. Speaker, this report, carefully typed, along with other files, was reposing in a brown brief case. I stepped into the Copper Cup Room tonight and desiring not to be handicapped in reaching with either hand, I set it aside for a few moments and it disappeared. Now, I might give a lecture on the evils of drink, but I am much more interested in getting back the brief case. So if any of you hear of a brown case with the name "Powell" inscribed thereon, you will earn my everlasting gratitude by returning it.

VICE-SPEAKER ASKEY: This report, being an addendum, to the Council Report, will be referred to Reference Committee No. 2.

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Report: Committee on Hospitalization Subsidy

The *Committee on Hospitalization Subsidy*, by John H. Shephard, Chairman. Doctor Shephard.

DOCTOR SHEPHARD: We were very pleased when the House of Delegates appointed this Committee in 1941 to investigate this hospital subsidy, but we are unprepared to submit any comprehensive report at this time. Contact was made with the California Hospital Association which appointed a Committee to study this in con-

nection with your committee. The question of legality of the hospital subsidy has been given some study, but a final legal opinion has not been secured. It is possible that, before such a plan could be operated, some constitutional amendment would be required. Contact has been made with various Grange groups all showing deep interest in the subject. Various Senators and Assemblymen have been interviewed. While all seem to recognize the merit and justice of such a plan, they were opposed to any action which would require any new or shifting tax burdens at this time. On account of the increased wages, and the decreased unemployment which, during the past year, has had a favorable reflection on the physician's income, many doctors are less interested in any change of the ways and means for the payment of medical costs. Your Committee believes that now is the time to give careful study, not only to the question of hospitalization subsidy, but to all phases of medical economics, so that when the post-war depression comes, we may have plans to meet it, which will preserve the highest type of medical service for all the people. We should not imitate the Indian who, through warm and dry weather, needs no roof on his tepee, and when it is cold and rainy, he can't build one. Your Committee suggests that this or a similar Committee be allowed to continue the subject of hospitalization subsidy.

VICE-SPEAKER ASKEY: Thank you Doctor Shephard. This report will be referred to Reference Committee No. 3.

The next report is from the *Committee on California Industrial Accident Commission Fee Schedule*, Doctor Morton S. Gibbons, Chairman.

Report: On Industrial Accident Commission Fee Schedule

DOCTOR MACDONALD: Your Committee met on several occasions to discuss the Fee Schedule and had some difficulty at arriving at a basis for it. However, they finally felt that the fee schedule should be increased 50 per cent for home office and hospital visits, and 25 per cent for hospital schedules that are in effect at the present time. That was taken up with the Council of the California Medical Association which agreed with it and this will be taken up with the Industrial Accident Commission. Doctor Gibbons sent this afternoon a supplementary report of the Committee on Industrial Accident Practice Fee Schedule. There are several points that should be considered in discussing augmentation of the Industrial Accident Fee Schedule. First, increasing minimum fees paid for medical and surgical services; second, the ability of the Industrial Accident Commission to enforce the payment of fees according to any schedule; third, attitude of the State Compensation Insurance Fund in ignoring the Industrial Accident Commission's schedule; fourth, the practice of certain physicians, individuals and groups in accepting fees lower than schedules; and fifth, the attempt of insurance companies to avoid the services of physicians who insist on payment of accounts equal to schedule. The Council of the California Medical Association has approved the report of the Special Committee. The State Commission agrees to meet a delegation of the California Medical Association, on a date to be arranged. The Commission sets fees in cases where the injured person has been treated by his own physician, and has not had the services of a physician supplied to him by employers or insurance companies. The Commission will consider fees and cases where the doctors and the injured join in a request to the Commission for an adjustment of fees. The Industrial Accident Commission does not exact adherence to the fees schedule by the insurance companies. The attitude of the State Com-

pensation Fund has always been to pay the minimum fee, maintaining that as the maximum fee. Certain physicians have also been willing to work for a cut-rate, and will continue to do so even if the fee schedule is augmented unless some mechanism is devised to prevent it. Insurance companies have, in the past, severed contact with the physicians who have been importunate about their fees, and required them to live up to their schedule. . . . (Referred to Committee No. 3.)

The next report will be from the *Committee on Medical Preparedness*, Dr. Fletcher, Chairman. Doctor Fletcher.

Report: Committee on Medical Preparedness

DOCTOR FLETCHER: The following is a report to date of the activities of the Committee on Medical Preparedness. Until the outbreak of the War on December 7, 1941, this Committee, under the chairmanship of Doctor Philip K. Gilman, had already completed a great amount of work. The work of completing the questionnaire which was sent out in 1940 to every doctor in the United States by the National Committee of Medical Preparedness of the American Medical Association had been successfully accomplished. The task of obtaining physicians for medical examinations, advisory boards for the Selective Service and the Field Board work had been carried out and was working smoothly. Regarding the Selective Service Board, there have been several changes in the method of examining inductees and registrants, and in this work the Committee has coöperated with the Selective Service to the fullest extent.

Following the outbreak of the War on December 7th, the question of Civilian Defense, here in California particularly, became one of great importance. There had been a great deal of work done in the target areas, but on a State level the work was confused and far behind where it should be. Doctor Bertram Brown, who is the Director of Public Health of the State of California was appointed by Governor Olsen to act as chairman of the State Sub-committee on Health of the Committee on health, welfare and consumer interest of the California State Council of Defense.

In January, Doctor Brown appointed to this Committee Doctor Charles Smythe of San Francisco, Doctor O. D. Hamlin of Oakland, and Doctor Harold Fletcher of San Francisco. Doctor Brown appointed a similar Committee in Los Angeles, and divided the work of the Committee between the Northern and Southern Divisions. The members of the Southern were Doctor Wallace Dodge, Doctor L. A. Alesen, and Doctor Elmer Dahl. The work of the two Committees have paralleled each other. We were able to obtain the appointment by Governor Olsen of three full-time officers, with a budget to cover salary and expenses. Mr. Thomas Clark was made chief emergency hospital officer for the State. Doctor Morton R. Gibbons of San Francisco was made chief emergency medical officer for the northern half of the State, and Doctor Charles Francis Sebastian, chief emergency medical officer for the southern part of the State. These three men are coördinating the work of Civilian Defense from a medical standpoint throughout the State. Doctor Brown is Chairman of the State Committee as a whole, and has put in a great deal of time; and through his efforts the work of this Committee has gone on smoothly.

California Procurement and Assignment Service

In January, your Chairman was appointed California State Chairman of the Procurement and Assignment Service for Physicians; and I feel that a brief report of the activities of this important department should be incorporated in the report of the Medical Preparedness Committee. The work of the Procurement and Assign-

ment Service has entirely superseded all work in Medical Preparedness. My appointment came about through the recommendation of the C.M.A. Executive Committee and the recommendation of Doctor Charles A. Dukes, who was at that time Chairman of the Ninth Corps Area of the Procurement and Assignment Services. As you remember, Doctor Dukes had been previously Chairman of the Ninth Corps Area of the Committee of Medical Preparedness. The State Committee of Medical Preparedness is composed of one doctor, one dentist, and one veterinarian. My instructions were to appoint such local Committees for the State of California as were necessary to cover the work of the Procurement and Assignment Services. In appointing these Committees I asked for the recommendations of the President and Secretary of each County Medical Society according to the groupings of the California Medical Association. I asked the President and Secretary of each component Society to give me able, well-balanced and, if possible, older men on their committees. In the case where counties were in concentrated localities and cities, I asked the President of a County Society to appoint its own subcommittee to carry on its work. In almost 100 per cent of the cases, various county medical societies have recommended for appointment very excellent men. I have received almost 100 per cent cooperation from the various local and county committees. The tasks given to these committees in some cases have been enormous. The amount of detailed work in making up county surveys and reporting on the availability or non-availability of doctors applying for service in the military forces, and the attempts and intelligent consideration and thought of these committees facing their various problems that arise can only partly be conceived by most men who have not come in contact with this work. There is a tremendous amount of responsibility involved in this work on the part of the County and Local Committees. In such a big undertaking there was bound to be confusion through lack of clear-cut instruction in the beginning. The Central Board in Washington grew from a small corner in another office to an office of their own, and then to a building of their own, and I now understand they are going to move to still, larger quarters. I want here to express personally my appreciation and thanks to every member of these Committees for the way they have assumed their responsibility, and the responsibilities of the medical profession in carrying out this great program. I have not considered myself as a State Committee, but I have considered myself only in the light of the Chairman of a State Committee composed of the Chairmen of the various County Society Committees. I am meeting, and have been meeting with practically all of the County Committees in the State, and gradually we have been able to clarify a great many confused policies and ideas. I wish to append to this report a list of these County Chairmen and again thank them for their wonderful cooperation.

Some of you may not realize that the Procurement and Assignment Service is not a part of the American Medical Association nor a part of the State Medical Association. It is definitely a Federal Agency under the Federal Security Agency and a department of the Office, Health, and Welfare Services; therefore the members of these Committees are not considering themselves as working as members of the California Medical Association or the Local County Societies, but a part of a definite Federal Agency. The reasons for this are obvious. The Agency was created and organized by the American Medical Association, and its structure was approved by the House of Delegates of the American Medical Association, and it was recommended to President Roosevelt that he create the Procurement and Assignment Services as it is set up. The appointments to the Central Board and right down through the Corps Areas of the State

Chairman and County Societies are all made through the recommendation and cooperation of the State Medical Societies and County Societies. This tremendous job has been put in the hands of the medical profession, and they have assumed the responsibility of making it a success. If we do not succeed, there are all too many forces ready to put this purely medical problem in the hands of lay directors; thus taking out of the hands of members of the medical profession any opportunity of controlling their destiny.

I feel that every physician should read carefully the article from the Procurement and Assignment Services in the February 21, 1942 issue of the *Journal of American Medical Association*, and then continue to follow in succeeding issues the items regarding Procurement and Assignment. If one takes the time to study the reasons behind this agency, and does a little bit of intelligent thinking on it, one will see many reasons why it must succeed and not fail. (Applause.)

VICE-SPEAKER ASKEY: Thank you very much, Doctor Fletcher for this report. I will refer it to Reference Committee No. 3. This is the last report of the Standing and Special Committees, and at this time I will return the gavel to our Speaker, Dr. Goin.

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Amendments to the Constitution

SPEAKER GOIN: On your program you will note three Constitutional Amendments pending, actually there are four. All which were introduced at the last session of the House, have been printed twice, and laid upon the table of the House for one year. The program is in error by reason of a misprint. These amendments are about to be committed. To avoid any misunderstanding, the Chair is now going to rule that the Committee to which these amendments are referred has the power to make certain changes in their wording. On one occasion, we had a very serious debate in the House because a reference Committee made a small alteration to an amendment. The Chair, therefore, rules the Committee has power to make changes in the amendment, provided that the modification of the rule to be amended is not exceeded. That very formidable sounding phrase means this, that if there were a by-law or a constitutional provision providing that the President, Doctor Rogers, should receive a magnificent sum of \$25 a year and a patriotic delegate named Palette introduced an amendment to provide for a salary of \$50 a year, and that amendment were referred to a Committee, the situation would be this. The mover of the amendment obviously didn't believe that \$25 a year was enough. He obviously didn't believe that \$50 a year or above \$50 a year was desirable, so that \$25 is the Constitutional limit already fixed and \$50 is the limit fixed by the mover of the amendment. The Committee in that instance would have the power to recommend that the salary be made \$26 or \$49 but not \$51 or \$24. Within those limits, the Committee has the power to make changes in the amendments, and these amendments are now referred to Reference Committee No. 3.

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NEW BUSINESS: RESOLUTIONS

The House is now open for the introduction of new resolutions and new business. May I remind you, please, that the meeting is being recorded electrically, the Speaker knows many of your names, the machine doesn't know any of them. When you arise to introduce a resolution, will you please state your name and county. Are there no resolutions to be introduced, no new business? Doctor Ayres of Los Angeles County.

Re: Industrial Accident Code

DOCTOR SAMUEL AYRES, Los Angeles: Mr. Speaker, Members of the House of Delegates: As Chairman of the Legislative Committee of the Los Angeles County Medical Association, I wish to introduce the following resolution:

WHEREAS, A situation has developed in the field of compensation insurance practice in which abuses are regularly occurring regarding the compensability of certain cases; and

WHEREAS, These abuses are harmful to the interests of employees in some cases, of employers and insurance carriers in others, and of the medical profession in still others; and

WHEREAS, Certain State Medical Associations, such as the New York State Medical Association, have recently enacted amendments to the industrial accident code which have corrected these abuses to the satisfaction of all parties concerned; therefore, be it

Resolved, That the Legislative Committee of the California Medical Association be instructed to prepare or approve suitable amendments to the industrial accident code which will eliminate the aforementioned objectionable practices.

SPEAKER GOIN: This resolution will be referred to Reference Committee No. 3. Doctor Madeley of Solano County.

Re: Subversive Activities

DOCTOR MADELEY, Solano County: Mr. Speaker, as a delegate of Solano County, I wish to introduce the following resolution:

WHEREAS, The Members of the Medical Profession are, and have been since the formation of the Republic, loyal, patriotic citizens; and

WHEREAS, In times of peace and in time of war the members of our profession have devoted their energies, their material resources and, when occasion demanded, their lives for the protection of the lives and property of their fellow citizens and for the preservation of the American way of life; and

WHEREAS, There are within the State of California a number of medical men licensed to practice the healing art in the State of California who are so lost to a sense of decency, and so lacking in these honorable qualities which for all times have characterized the members of the medical profession, that they have been guilty of subversive activities and of giving aid and comfort to the enemies of the United States; and

WHEREAS, It is the opinion of the members of the House of Delegates here assembled that medical practitioners guilty of such unethical and vile practices should no longer be allowed to legally practice the healing art; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association, in convention duly assembled, does hereby instruct the members of the Committee on Public Policy and Legislation, and the General Counsel of the Association to consult with the members of the Board of Medical Examiners and such other bodies as they deem wise, to the end that enabling legislation be introduced at the next session of the California Legislature which will make such practice of subversive activities, and the giving of aid and comfort to the enemies of the United States of America, cause for the revocation of the license to practice held by those guilty of such unAmerican and unethical activities. (Applause.)

SPEAKER GOIN: This resolution will be referred to Reference Committee No. 3. Doctor Russell Fletcher of San Francisco.

Re: Relation of State Association and Component County Units

DOCTOR RUSSELL FLETCHER, San Francisco: I wish to introduce this resolution:

WHEREAS, The unity of the medical profession is paramount in the interests of each individual practitioner, each component county society and, indeed, in the welfare of each individual in the State; and

WHEREAS, It is customary in all democratic organizations to be guided by the majority vote of duly elected representatives, and to abide by that vote until a majority decides to rescind or amend it; and

WHEREAS, The House of Delegates of the California Medical Association represents all of the doctors who are members of organized medicine in this State; now, therefore, be it

Resolved, That the members of this House reaffirm their belief in the principles of Democracy, and therefore agree to abide by the decisions of the majority in all matters acted upon by this House; and be it further

Resolved, That, in medical affairs State-wide in scope, the actions of this House of Delegates, binding as they are on all delegates, the individual members of the Association, shall equally be binding on all component county society units of the Association. (Applause.)

SPEAKER GOIN: Referred to Reference Committee No. 3. Doctor L. H. Garland of San Francisco.

Re: Relations between Physicians and Insurance Companies

DOCTOR L. H. GARLAND, San Francisco: This resolution is introduced from the San Francisco delegation. It concerns improvement of relations between physicians and insurance companies.

WHEREAS, It is desirable that physicians and insurance companies cooperate to the fullest extent, especially in the interest of persons covered by health and accident insurance; and

WHEREAS, A serious situation has arisen in the administration of certain health and hospitalization schemes whereby medical services are being billed under the term "hospital services," and are being paid for by insurance companies *only so long* as they are labeled hospital services; and

WHEREAS, The continuation or extension of such practices will inevitably lead to the inclusion of any type of medical service under the label "hospital service," at the convenience of the corporations involved, and to the detriment of medical care; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association hereby requests insurance companies to cooperate with the organized medical profession to the end that hospitalization policies shall include only hospital benefits. If the inclusion of indemnification for medical service (such as surgery or radiology) is desired, then payment of such shall only be made on receipt of certified statement from a physician that he has rendered such. Fees for medical services should be paid to physicians (via indemnity to the assured, or by check payable jointly to assured and physician). This practice should be maintained irrespective of whether a hospital chooses to bill for medical services as a part of its hospital bill; and be it further

Resolved, That the House of Delegates of the California Medical Association requests hospitals and physicians to cooperate with it in this important step, by seeing that bills for hospital and medical services are clearly distinguished; the latter should bear the name of the physician rendering the service to indicate clearly that the charge is for medical service.

SPEAKER GOIN: Referred to Reference Committee No. 3. Further resolutions? Wilbur Bailey of Los Angeles.

Re: Rebates

WILBUR BAILEY, Los Angeles:

WHEREAS, The Principles of Ethics of the American Medical Association in Chapter III, Article 13, Section I, state that "The obligation assumed by a physician on entering the profession . . . demands that he use every means to uphold the dignity and honor of his vocation and to exalt its standards"; and

WHEREAS, Section 5 of the same Chapter states: "It is unprofessional to receive remuneration from patients on surgical instruments or medicine; to accept rebates on prescriptions or surgical appliances, or perquisites from attendants who aid in the care of patients; and

WHEREAS, Article VI, Section 3, of this Chapter states: "When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or receive a commission by whatever term it may be called or by any guise or pretext whatsoever; and

WHEREAS, Section 4 of this same Article states: "It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or

however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy; and

WHEREAS, Recent articles in magazines of wide national circulation have called attention to shady practices of secret rebates to physicians; and

WHEREAS, Commercial concerns and laboratories, by the employment of cappers and steerers, and by secret rebating are largely responsible for these criticisms; and

WHEREAS, The Better Business Bureau has complained of practices in which secret rebates were offered or accepted by physicians; and

WHEREAS, The dishonest acts of a few may be reflected to the discredit of the many; now, therefore, be it

Resolved, That it be declared unethical for the members of the California Medical Association or its component branches to refer patients to commercial organizations, laboratories, or other physicians who advertise, employ steerers of cappers, offer or pay rebates or commissions or in any other manner violate the Code of Ethics of the American Medical Association and its component branches. (Applause.)

SPEAKER GOIN: Referred to Reference Committee No. 3. Are there any further resolutions to come before the House?

* * *

Re: Physicians' Benevolence Committee

SECRETARY KRESS: Mr. Speaker, Doctor Anderson of the Council of the California Medical Association, who is ill, has sent word that Doctor Young, of his district, will present some proposed amendments.

SPEAKER GOIN: Doctor J. E. Young of Fresno.

DOCTOR YOUNG, Fresno: Amendments to the by-laws of the California Medical Association, amending Section 23 of Chapter 5 of said by-laws.

Resolved, That Section 23 of Chapter 5 of the by-laws of the California Medical Association be amended by deleting from the title of said Section, the words "Committee on Aid to Needy Members" and substituting "Physicians' Benevolence Committee," by deleting from said Section the words, "Special Fund for Aid to Needy Members," and substituting "Physicians' Benevolence Fund." By adding to said Section after the last paragraph thereof, the following sentence: "The Executive Secretary of the Association shall act as Secretary of the Committee."

And by adding to said Section 23 at the end of the sentence which is preceded by the designation (a), the following clause, "Provided, however, that the Council must in each year allocate to, and place in the Physicians' Benevolence Fund, a sum equal to \$1 per active member of the Association, and to carry out the foregoing allocation, there shall be deposited in the Physicians' Benevolence Fund the sum of \$1 out of each payment of annual dues received from each active member."

So that hereafter said Section 23 of Chapter 5 will read as follows: "Section 23: Physicians' Benevolence Committee. The Physicians' Benevolence Committee shall consist of three members whose appointments and terms of office shall be as provided in Section 2 of this Chapter. The Committee shall be responsible to the Council and the House of Delegates for all of its activities. The Committee shall administer those funds of this Association hereinafter designated as comprising the Physicians' Benevolence Fund. The Committee's administration of said Fund shall be subject to the provisions of this Section. The Funds which may from time to time be allocated to it from the general funds of the Association by the Council are the funds for this Committee, provided, however, that the Council must in each year allocate to, and place in the Physicians' Benevolence Fund, a sum equal to \$1 per each active member of the Association; and to carry out the foregoing allocation, there shall be deposited in the Physicians' Benevolence Fund the sum of \$1 out of each payment of annual dues received from each active member."

(b) "All requests, voluntary contributions and donations from any source whatever, that may be received by this Association for the express and implied purpose of aiding needy members or their dependents; and

(c) "All other funds from whatever source derived,

except Accounts Receivable, payments for indebtedness to this Association, dues and assessments received by this Association where the payer, donor, or other persons transferring the funds express the intent that such funds shall be for aid to needy members. Funds contained in the Physicians' Benevolence Fund may from time to time be dispersed by the Physicians' Benevolence Committee. The Executive Secretary of the Association shall act as Secretary of the Committee." (Applause.)

DOCTOR YOUNG, Fresno: Herewith, also a proposed amendment to the Constitution of the California Medical Association, Article XI, Section I:

Resolved, That Section 1 of Article XI of the Constitution of this Association, California Medical Association (b) and the same hereby is amended by adding to said Section at the end thereof, the following paragraph: "At least \$1 out of the annual dues paid by each member of the Association shall be allocated to the Physicians' Benevolence Fund and shall only be used for the purposes as set forth in the by-laws."

SPEAKER GOIN: We have here two matters:

The Constitutional Amendment that applies to Article XV of the constitution will lie upon the table of the House for one year.

As to the Amendment of the by-laws, in case any of you think you are undergoing an individual experience, please allow the Chair to assure you that you are no more bewildered than the Chair is with this page of legal phraseology. I have found by inquiring this afternoon that the intent is to add this to the by-laws. We thought at first we would have to add the by-laws to this. I would like to ask Mr. Peart to explain to us in words of one syllable just what this means.

MR. PEART: It is Doctor Anderson's purpose to allocate \$1.00 out of the dues of each active member for this fund in the name of the Committee, and to put the handling of these funds entirely in the hands of this Committee without power to the Council.

SPEAKER GOIN: Rather than in the hands of the Council? This by-law may be adopted at the next session of the House of Delegates. It will be reported to Reference Committee No. 3.

* * *

Are there any further resolutions? If there are not, the Chair will remind you that tomorrow the Reference Committees will hear your objections to or arguments in support of any matters brought up tonight. That each one of you and any member of the Association has not only the right, but also the absolute duty to appear before these Committees to make known your views on these various matters.

If the Committee Chairmen, before leaving the room, will come to the Secretary's desk, each will then be presented with a folio containing the matters referred to his respective Committee. The Committee Chairmen are:

J. Norman O'Neill, Chairman of *Reference Committee No. 1*, which is the *Committee on the Reports of Officers and Standing Committees*. His Committee will meet tomorrow in the Billiard Room. Reference Committee will meet at 10 o'clock tomorrow morning in the Billiard Room.

Reference Committee No. 2 of which Doctor L. Henry Garland is Chairman. This *Committee on the Reports of the Council and Secretary-Treasurer* will meet in the Game Room which is on the ground floor opposite the elevator. This Committee will meet at 8 o'clock tomorrow morning.

Reference Committee No. 3 to which all other matter have been committed, Doctor Dwight Wilbur, Chairman, will meet in the Board of Directors' Room on the mezzanine floor at 9 a.m. I dare say that it will be in session until 6 o'clock Wednesday evening, continuously, so you better get around early because they may be in trouble before that.

SPEAKER GOIN: The minutes of the House have been recorded electrically. The Chair will entertain a motion to approve the minutes.

DOCTOR JOHN CLINE: I so move.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Moved by Cline and seconded by Doughty of San Joaquin. All in favor say, "Aye," contrary, "No." The motion is carried. The Chair will now entertain a motion to adjourn.

DOCTOR JOHN CLINE: I so move.

DOCTOR DOUGHTY: I second the motion.

1 1 1

SPEAKER GOIN: The meeting is adjourned. The House will meet in this room tomorrow and not in the Bali Room, Wednesday at 5 o'clock. Incidentally, I think these are the nicest quarters ever provided for the House of Delegates meetings, and I think I voice the sentiment of the House when I say we thank the Hotel Del Monte management and Del Monte Properties Corporation, for bringing into realization this new Convention Pavilion, constructed in good part, according to sketches submitted by the chairman of the C.M.A. Committee on Scientific Work. Next meeting of the House of Delegates at 5 p.m., on Wednesday, in this same room. Please be prompt.

First meeting of the House of Delegates, at the 71st Annual Session, adjourned at 10:30 p.m., on Monday, May 4, 1942.

HOUSE OF DELEGATES: SECOND MEETING

Minutes of the Thirty-Ninth Annual Session of the House of Delegates of the California Medical Association.

Held at Hotel Del Monte, Del Monte, California, Monday, May 4, and Wednesday, May 6, 1942

Second Meeting, Wednesday Evening, May 6, 1942, in Room E, Convention Pavilion, Hotel Del Monte

The second meeting of the House of Delegates of the California Medical Association in their seventy-first annual session, held in the Hotel Del Monte, Del Monte, California, was called to order at 5:10 p.m., Speaker Lowell S. Goin presiding.

SPEAKER GOIN: Will the House be in order please? For the purpose of receiving a supplementary report of the Committee on Credentials, the Chair recognizes its Chairman, Doctor Halley. Doctor Halley.

DOCTOR HALLEY: Mr. Speaker, your Committee on Credentials reports a total of 78 delegates. I move you, sir, that the delegates who have been so recorded be seated.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: All those in favor say, "Aye," contrary, "No." The motion is carried. The next order of business is the Roll Call. To save the time of the House, if there is no objection, we will postpone the Roll Call until the recess session. Do I hear any objections? The Roll Call will be postponed until the evening session. The Secretary will announce the place and time of the 1943 session.

1 1 1

Re: Annual Session in 1943 Will be Held in Del Monte

SECRETARY KRESS: Mr. Speaker, the Council recommends to the House of Delegates that Hotel Del Monte be the meeting place for the Convention of 1943. The time will be determined by the Council at a later date. (Applause.)

Election of Officers

SPEAKER GOIN: The next order of business is the election of officers. Nominations are now open for the office of President-elect. Doctor Carr of San Francisco.

1 1 1

President-Elect: Karl M. Schaupp Elected

DOCTOR CARR, San Francisco: Mr. Speaker and Members of the House of Delegates: I would like to nominate for President-elect of the California Medical Association, Doctor Karl Schaupp. (Applause.) This nomination comes, of course, as the unanimous choice of the San Francisco delegation and of the San Francisco City and County Medical Society and, I think, probably comes from the hearts of all of us. It is asking a lot, I know, of a man of Doctor Schaupp's practice and of burdens at present to take this position and at such a time. He has, as you know, one son about to enter the service and one son still in Medical School, together with numerous other professional responsibilities and duties. We all know him, however, as a man who is so eminently suited to the position and in addition so deserving, that it is a great pleasure to present his name. (Applause.)

SPEAKER GOIN: Doctor Karl Schaupp is now nominated. Are there any further nominations? If there are none, the Chair will declare the nominations closed. Hearing none, the nominations are closed. How will we vote?

UNIDENTIFIED VOICE: By acclamation!

SPEAKER GOIN: All those in favor say, "Aye," contrary, "No." Doctor Schaupp is unanimously elected. (Applause.) (Vice-Speaker Askey takes the Chair.)

1 1 1

Speaker of the House: Lowell S. Goin Elected

VICE-SPEAKER ASKEY: The next office to be filled is Speaker for the House of Delegates. Are there any nominations for this office? Doctor Palette.

DOCTOR PALETTE: Gentlemen, I have in my library at home several hundred Lincoln books. Lincoln has said very many wise things, but you will all remember very well, it was he who said, "Do not change horses in the middle of the stream." We are in the middle of the stream. I have sat through ten or twelve meetings of the House of Delegates of the American Medical Association and had opportunity to observe several speakers in action there. I have also observed more or less closely several speakers in this House of Delegates, and I am very glad that I am able to say now that I have not known of any speaker in any medical group who is quite as efficient as the Speaker that this House has had during the last couple of years. I take great pleasure in nominating Doctor Lowell Goin to succeed himself. (Applause.)

VICE-SPEAKER ASKEY: You have heard the nomination of Doctor Goin. Are there further nominations for this office?

UNIDENTIFIED VOICE: I move the nominations be closed.

UNIDENTIFIED VOICE: I second the motion.

VICE-SPEAKER ASKEY: It is not necessary to have a motion. Hearing no further nominations the Chair declares the nominations are closed. How will you vote.

UNIDENTIFIED VOICE: By acclamation!

VICE-SPEAKER ASKEY: All those in favor say, "Aye," opposed, "No." Doctor Goin is elected Speaker of the House. (Applause.) (Speaker Goin resumes the Chair.)

1 1 1

Vice-Speaker: E. Vincent Askey Elected

SPEAKER GOIN: Thank you gentlemen. The next office to be filled is that of Vice-Speaker. Doctor Kiger of Los Angeles.

DOCTOR KIGER: I would like to place in nomination the name of E. Vincent Askey. I have placed his name in nomination every time he has come up, so I guess I will have to do it again. (Applause.)

SPEAKER GOIN: Doctor Askey is nominated. Are there any further nominations? If there are none, the Chair will declare the nominations closed. Hearing none, the nominations are closed. How will you vote? All in favor say, "Aye," contrary, "No." Doctor Askey is unanimously elected. (Applause.)

* * *

District Councilors: Donald Cass, R. Stanley Kneeshaw, and Frank A. MacDonald Elected

We now come to the nominations for District Councilors.

Councilor for the Second District, Doctor Donald Cass, incumbent, term expiring. Doctor Alesen of Los Angeles.

DOCTOR ALESEN: It gives me great pleasure to endorse the nomination of Doctor Cass to succeed himself, for Councilor of the Second District.

SPEAKER GOIN: Doctor Cass is nominated. Are there any further nominations? If there are none, the Chair will declare the nominations closed. Hearing none, the nominations are closed. Will you vote by acclamation? All in favor say, "Aye," contrary, "No." Doctor Cass is unanimously elected.

* * *

Councilor of the Fifth District, Doctor Stanley Kneeshaw of San Jose, incumbent, term expiring. Doctor Shephard of San Jose.

DOCTOR SHEPHARD: The delegates from the Fifth Council District by the Rules and By-laws have placed in nomination their candidate for the Councilor of the Fifth District with the Secretary.

SECRETARY KRESS: Mr. Speaker, the Fifth Council District delegates have presented in writing the nomination of R. Stanley Kneeshaw.

SPEAKER GOIN: Doctor Kneeshaw is nominated. . . . Doctor Kneeshaw is elected. (Applause.)

* * *

The Eighth District. Doctor Frank MacDonald of Sacramento, incumbent, term expiring. Doctor Scatena of Sacramento.

DOCTOR SCATENA: The delegates from the Eighth District, through written nomination, wish to place in nomination the name of Doctor MacDonald to succeed himself.

SPEAKER GOIN: Doctor MacDonald is nominated. . . . Doctor MacDonald is elected. (Applause.)

* * *

Councilors-at-Large: Sam J. McClendon and Edwin L. Bruck Elected

Councilors-at-Large, Doctor Sam McClendon of San Diego, term expiring. Doctor Johnston of Orange County.

DOCTOR JOHNSTON: The delegates of the First District met together and desire to have the name of Doctor Sam McClendon placed in nomination to succeed himself.

SPEAKER GOIN: Doctor McClendon is nominated. . . . Doctor McClendon is elected. (Applause.)

* * *

Doctor Edwin L. Bruck of San Francisco, term expiring. Doctor Garland of San Francisco.

DOCTOR GARLAND: We wish to place in nomination the name of Doctor Edwin L. Bruck to succeed himself.

SPEAKER GOIN: Doctor Bruck is nominated. Are there any further nominations? . . . Doctor Bruck is elected. (Applause.)

Delegates to A.M.A.: Edward N. Ewer, Edward M. Palette, Robert A. Peers, Wm. R. Molony, and Dwight L. Wilbur Elected

The Delegates to the American Medical Association. Edward N. Ewer of Oakland, term expiring. He is an incumbent. Doctor Jelte.

DOCTOR JELTE: I would like to place in nomination the name of Edward N. Ewer, in behalf of the Delegates from Alameda County.

SPEAKER GOIN: Doctor Ewer has been nominated. . . .

* * *

Doctor Ewer is elected. Doctor Edward M. Palette of Los Angeles, incumbent, term expiring. Doctor Brownfield of Los Angeles.

DOCTOR BROWNFIELD: It gives me pleasure to place in nomination the name of Doctor Edward Palette to succeed himself.

SPEAKER GOIN: Doctor Palette is nominated. Are there any further nominations? Hearing none, the nominations are declared closed. All in favor of the election of Doctor Palette say, "Aye," contrary, "No." Doctor Palette is elected. (Applause.) Doctor Robert A. Peers of Colfax, term expiring. Doctor Miller of Placer-Nevada-Sierra County.

* * *

DOCTOR MILLER: I would like to enter the nomination of Doctor Peers to succeed himself.

SPEAKER GOIN: Doctor Peers is nominated. Are there any further nominations? . . . Doctor Peers is elected. (Applause.)

* * *

Doctor William R. Molony, Sr. of Los Angeles, term expiring. Doctor Hayes.

DOCTOR HAYES: I would like to place in nomination Doctor W. R. Molony, Sr., to succeed himself.

SPEAKER GOIN: Doctor Molony is nominated. . . . Doctor Molony is elected. (Applause.)

* * *

DOCTOR CHANDLER: I would like to place in nomination the name of Dwight Wilbur to fill the unexpired term of Doctor Best.

SPEAKER GOIN: Doctor Chandler has nominated Dwight Wilbur. Doctor Wilbur is nominated. Are there any further nominations. . . . Doctor Wilbur is elected.

* * *

Alternates to A.M.A.: Frank R. Makinson, William H. Kiger, Frederick Scatena and Ralph Eusden Elected

Alternates to the American Medical Association. Each alternate elected is an alternate to a particular delegate.

The first alternate is an alternate to Doctor Ewer. Doctor Makinson is the present incumbent, term expiring. Doctor Smith of Alameda County.

DOCTOR SMITH: The delegation of the Alameda County wishes to place in nomination the name of Frank R. Makinson to succeed himself.

SPEAKER GOIN: Doctor Makinson is nominated. Are there further nominations? . . . Doctor Makinson is elected.

* * *

Alternate to Doctor Edward N. Palette. William H. Kiger of Los Angeles, incumbent, term expiring. Doctor Blatherwick.

DOCTOR BLATHERWICK: The Los Angeles delegation takes pleasure in placing in nomination the name of Doctor Kiger to succeed himself.

SPEAKER GOIN: The name of Doctor Kiger has been placed in nomination. . . . Doctor Kiger has been elected.

* * *

Alternate to Doctor Robert A. Peers. Frederick Scatena of Sacramento, incumbent, term expiring. Doctor

Jones of Sacramento.

DOCTOR JONES: Mr. Speaker, I should like to place in nomination the name of F. N. Scatena to succeed himself as alternate to Doctor Peers.

SPEAKER GOIN: Doctor Scatena has been nominated.
... Doctor Scatena is elected.

* * *

Alternate to William R. Molony, Sr. Doctor John C. Ruddock, incumbent, term expiring. Doctor Wilcox.

DOCTOR WILCOX: I would like to place in nomination the name of Doctor Eusden of Los Angeles. Dr. Ruddock is in service and states he cannot act as alternate.

SPEAKER GOIN: Doctor Eusden has been nominated.
... Doctor Eusden is elected.

* * *

Standing and Special Committees

The Special Committee on Nominations of Committee Members will kindly announce the members of the Standing Committees elected by the Council, with the approval of the House.

SPEAKER GOIN: The Chair recognizes Doctor Kneeshaw.

DOCTOR KNEESHAW: Your committee respectfully reports the selection of the following personnel for your Standing and Special Committees for 1943.*

Committee on Associated Societies and Technical Groups:
Clarence Rees, M. D., San Diego.....1945
John V. Barrows, M. D., Chairman, Los Angeles..1943
Edwin L. Bruck, M. D., San Francisco.....1944

Committee on Health and Public Instruction:
J. C. Geiger, M. D., San Francisco.....1943
John Ruddock, M. D., Chairman, Los Angeles....1944
Cecil M. Burchiel, M. D., San Jose.....1945

Committee on History and Obituaries:
Hyman Miller, M. D., Los Angeles.....1943
Morton Gibbons, M. D., Chairman, San Francisco.1944
Robert A. Peers, M. D., Colfax.....1945
George H. Kress, Secretary-Editor, Ex Officio

Committee on Hospitals, Dispensaries and Clinics:
Benjamin Black, M. D., Oakland.....1943
Walter Rapoport, M. D., U.S. Navy, Mare Island.1944
J. Norman O'Neill, M. D., Chairman, Los Angeles.1945

Committee on Industrial Practice:
George H. Sanderson, M. D., Stockton.....1943
Wilbur Cox, M. D., San Francisco.....1944
Donald Cass, M. D., Chairman, Los Angeles.....1945

Committee on Medical Defense:
Lewis T. Bullock, M. D., Los Angeles.....1943
Nelson Howard, M. D., Chairman, San Francisco.1944
Stanley Kneeshaw, M. D., San Jose.....1945

Committee on Medical Economics:
Glenn Cushman, M. D., Chairman, San Francisco.1943
Edward C. Pallette, M. D., Los Angeles.....1944
Charles A. Broadus, M. D., Stockton.....1945

Committee on Medical Education and Medical Institutions:
Fred H. Kruse, M. D., San Francisco.....1943
B. O. Raulston, M. D., Chairman, Los Angeles...1944
L. R. Chandler, M. D., San Francisco.....1945

Committee on Membership and Organization:
L. H. Redelings, M. D., San Diego.....1943
Louis Alesen, M. D., Chairman, Los Angeles.....1944
J. F. Doughty, M. D., Tracy.....1945

Committee on Postgraduate Activities:
Francis Rochex, M. D., Chairman, San Francisco.1943
Fred Clark, M. D., Vice-Chairman, Long Beach..1944
(To fill the unexpired term of F. E. Clough, M. D., resigned.)

Frank MacDonald, M. D., Sacramento.....1945
George H. Kress, Secretary, Ex Officio
We recommend that Dwight Wilbur, M. D., San Francisco, act on the Advisory Committee.

Committee on Publications:

George W. Walker, M. D., Chairman, Fresno....1943
F. Burton Jones, M. D., Vallejo.....1944
(To fill the unexpired term of Doctor Alexander of Oakland, deceased.)
Francis E. Toomey, M. D., San Diego.....1945
George H. Kress, Secretary-Editor, Ex Officio

Committee on Public Policy and Legislation:

E. T. Remmen, M. D., Los Angeles.....1943
Dwight H. Murray, M. D., Chairman, Napa.....1944
Anthony Diepenbrock, M. D., San Francisco.....1945

Committee on Public Policy and Legislation:

Advisory Committee:

Junius B. Harris, M. D., Chairman, Sacramento
H. R. Madeley, M. D., Vice-Chairman, Vallejo

Committee on Scientific Work:

Fletcher B. Taylor, M. D., Oakland.....1943
J. Homer Woolsey, M. D., Woodland.....1944
Howard F. West, M. D., Los Angeles.....1945
Secretary, Section on Medicine [Mast Wolfson, M. D., Monterey], Ex Officio
Secretary, Section on Surgery [J. Norton Nichols, M. D., Los Angeles], Ex Officio
Association Secretary [George H. Kress, M. D., San Francisco], Ex Officio, Chairman

Cancer Commission:*

[Harold Brunn, M. D., Chairman, San Francisco]
Lyell E. Kinney, M. D., Vice-Chairman, San Diego.1943
Otto H. Pflueger, M. D., Secretary, San Francisco1943
Orville N. Meland, M. D., Los Angeles.....1944
A. Herman Zeiler, M. D., Los Angeles.....1944
Gertrude Moore, M. D., Oakland.....1944
Alson R. Kilgore, M. D., San Francisco.....1943
Henry J. Ullmann, M. D., Santa Barbara.....1945
Clarence J. Berne, M. D., Los Angeles.....1945

Committee on Public Health Education:

Frank R. Makinson, M. D., Chairman, Oakland
P. K. Gilman, M. D., Chairman, San Francisco
Samuel Ayres (Jr.), M. D., Los Angeles
J. Frank Doughty, M. D., Tracy
Thomas A. Card, M. D., Riverside
Lowell S. Goin, M. D., Los Angeles
Dwight Murray, M. D., Napa
W. R. Molony, M. D., Los Angeles

Committee on Medical Benevolence:

Robert A. Peers, M. D., Colfax
Elizabeth M. Hohl, M. D., Los Angeles
Axcel E. Anderson, M. D., Chairman, Fresno

* * *

Editorial Board

Dwight L. Wilbur, Chairman of the Board

Executive Committee:

Dwight L. Wilbur, M. D., San Francisco
George W. Walker, M. D., Fresno
Albert School, M. D., Los Angeles
Fred D. Heegler, M. D., Napa

Anesthesiology:

Charles F. McCuskey, M. D., Chairman, Glendale
H. R. Hathway, M. D., San Francisco

Dermatology and Syphilology:

H. J. Templeton, M. D., Oakland
W. H. Peckerman, M. D., Los Angeles

* List is as amended.

* Nominations for Cancer Commission received from President-Elect Molony.

Ear, Eye, Nose, and Throat:

Fredrick C. Cordes, M. D., San Francisco
 L. G. Hunnicutt, M. D., Pasadena
 George W. Walker, M. D., Fresno

General Medicine:

Garnett Cheney, M. D., San Francisco
 Mast Wolfson, M. D., Monterey
 George Houck, M. D., Los Angeles

General Surgery, Including Orthopedics:

Fred C. Bost, M. D., San Francisco
 Clarence J. Berne, M. D., Los Angeles
 Fred D. Heegler, M. D., Napa

Industrial Medicine and Surgery:

John E. Kirkpatrick, M. D., Shasta Dam
 John D. Gillis, M. D., Los Angeles

Plastic Surgery:

George W. Pierce, M. D., San Francisco
 William S. Kiskadden, M. D., Los Angeles

Neuro-Psychiatric:

John B. Doyle, M. D., Los Angeles
 Olga Bridgman, M. D., San Francisco

Obstetrics and Gynecology:

Earl Hendriksen, M. D., Los Angeles
 Daniel G. Morton, M. D., San Francisco

Pediatrics:

William A. Reilly, M. D., San Francisco
 William W. Belford, M. D., San Diego

Pathology and Bacteriology:

David A. Wood, M. D., San Francisco
 R. J. Pickard, M. D., San Diego

Radiology:

R. R. Newell, M. D., San Francisco
 Henry J. Ullman, M. D., Santa Barbara

Urology:

Lewis Michelson, M. D., San Francisco
 Albert Soiland, M. D., Los Angeles

Pharmacology:

Chauncey P. Leake, M. D., San Francisco
 Clinton H. Thienes, M. D., Los Angeles

Further Recommendations:

Section A.—We respectfully recommend that legal counsel of the California Medical Association be instructed to draw up the necessary amendments to the by-laws for the deletion of the following Standing Committees.

1. Committee on Membership and Organization, by reason of their own suggestion as printed in the Pre-Convention Bulletin which indicates the Committee unnecessary.

2. The Committee on Publications, because last year the Editorial Board was created, and the Committee's duties were largely taken over by the new Board.

Section B.—We suggest that the Executive Members of the Standing Committees be circularized by the Association's Secretary for names of new Advisory Members to be appointed in accord with the Section 4, Chapter V, of the By-Laws. This to be done to add to the effectiveness of the work of the Committees and, further, that this Special Committee on Personnel of Committees of the Council be continued until such appointments have been made.

Section C.—It is further suggested that Commission Members who are now in the Commissioned Armed Services be contacted by the Association's Secretary to determine whether or not they wish to continue to serve on their respective Committees.

Respectfully submitted,

JOHN W. GREEN, *Chairman.*
 EDWARD B. DEWEY
 STANLEY KNEESHAW

DOCTOR KNEESHAW: I wish to move the adoption of this report.

SPEAKER GOIN: Doctor Kneeshaw moves the adoption of the report. Is there a second?

DOCTOR BRUCK: I second the motion. . . . The report is adopted.

' ' '

In Memoriam

During the past year, Members of the House, we have lost 74 of our members, friends, colleagues, by death. Perhaps the House would like to stand for a moment in tribute to this group. (List of deceased members appeared in April issue of CALIFORNIA AND WESTERN MEDICINE, on page 216.)

(House stood for one minute.)

' ' '

Recess

The Chair will entertain a motion to recess at this time, to convene again at 8 o'clock. It has been moved by Doctor Doughty of San Joaquin and seconded by Doctor Bailey. All in favor say, "Aye," contrary, "No." The House will be in recess until 8 o'clock.

' ' '

Second meeting of the House of Delegates, at the 71st Annual Session recessed at 5:40 p.m., on Wednesday, May 6, 1942.

* * *

After-Recess Meeting

House of Delegates: Reconvened at 8:30 p.m.

VICE-SPEAKER ASKEY: Will the House be in order. . . . Does the Credential Committee have a further report to make at this time? If there is nothing further from the Credentials Committee, we will proceed with the Roll Call, to constitute the House officially. Mr. Secretary, at the time of the Roll Call of the Delegates from each individual County, if the Chairman of that delegation wishes to seat an alternate, he will rise, give his name, and state to the Chair the alternate who will sit for the delegate. Mr. Secretary, please call the Roll.

(Secretary Kress called the roll of the House.)

VICE-SPEAKER ASKEY: Councilor Anderson is sick in bed, and that is the reason he is not here. The roll call having been completed, we will proceed. Is there a quorum present, Mr. Secretary?

SECRETARY KRESS: Mr. Speaker, a quorum is present.

VICE-SPEAKER ASKEY: A quorum being present, this House is declared duly open and constituted for further business. At this time, we will have a report from the Chairman of the Committee on Scientific Work, Doctor Kress, in regard to scientific prizes. Doctor Kress.

' ' '

Report of Committee on Awards for Scientific Exhibits

SECRETARY KRESS: Mr. Speaker, the Secret Committee on Scientific Exhibits has reviewed the exhibits and reports as follows:

1. First Prize (Fifty Dollars and Engrossed Certificate of Award), for best Surgical Exhibit was awarded to James R. Dillon, M. D., San Francisco, for exhibit on "*Conservative Treatment of Cancer of the Prostate.*"

2. Honorable Mention (Engrossed Certificate) was awarded to Bernard Strauss, M. D., San Francisco, and Henry Kreutzman, M. D., for exhibit, "*Anatomy of the Perivesical Spaces.*"

3. First Prize (Fifty Dollars and Engrossed Certificate of Award) for best Medical Exhibit was awarded to Samuel Ayres, Jr., M. D., Los Angeles, and Nelson Paul Anderson, M. D., Los Angeles, for exhibit, "*Dermatoses Common Under War Conditions.*"

4. Honorable Mention (Engrossed Certificate) was awarded to G. R. Biskind, M.D., San Francisco, and Bernard Strauss, M.D., San Francisco, for exhibit, "*Hormonal Treatment of Eunuchoidism.*"

The report on the Drawing of Prizes for visits to the Technical Exhibits. Executive Secretary Hunton states that the drawings are not yet completed, and those who won the radio, and the electric clock and fountain pen, will receive their prizes in due course.

REPORTS OF REFERENCE COMMITTEES

At this time, we will come to the report of our various Reference Committees. The first Reference Committee Report is Reference Committee No. 1. Its report on the Reports of the Officers and Standing Committees. The Chairman of that Committee is Doctor J. Norman O'Neill of Los Angeles County. Doctor O'Neill.

* * *

REPORT OF REFERENCE COMMITTEE NO. 1

DOCTOR O'NEILL: Mr. Speaker, your Reference Committee No. 1 to which was referred Reports of the Officers and Standing Committees* begs leave to report as follows:

Report of the President:

The outbreak of the World War No. 2 in the middle of the Association's year brought about profound changes in the program and has produced numerous problems which it will be the duty of the Association's Officers and Councilors to solve. . . .

Today, we face a serious situation. There are a large percentage of medical men who are entering the service of the Army and Navy. This leaves a problem for the physicians who are left at home. From this situation we can expect that the practice of private medicine in civilian communities will undergo a change in the next year or two. If the physicians of the State can meet this changing situation through their own organization, they will be able to control the situation. If they cannot meet this challenge, it is certain that the Government will do so.

We are fortunate in California in having a well organized Medical Service, completely in touch with present and future demands on the medical profession. It is our President's sincere belief that this organization will enable the physicians of our State to remain in control of their own destiny, no matter what changes might come about in medical practice because of the war or Government demands. California Physicians' Service has entered into partnership with the United States Government on two occasions in the year now ending. For the Farm Security Administration, it has contracted to provide adequate medical care for farm families and for the Federal Works Agency. It has agreed to look after the residents of Defense Housing Units in two California locations. Both of these agreements have far reaching significance. The contracts prove at once that C.P.S. is reaching its maturity along the lines of its original conception, and that it is undoubtedly the best bulwark possessed by the medical profession against threatened inroads of Governmental Agencies. Internally, the administrative changes already made and under contemplation by C.P.S. should result in further progress of the organization, and a better return to the participating professional members. Our President, within the last month, has

been called upon to do one more duty—the Office of Chairman of the Ninth Corps Area Committee of the Procurement and Assignment Service. This appointment was made immediately after the death of beloved Charles A. Dukes. It carries with it a responsibility for the maintenance of professional standards and medical care for the civilian population, as well as the building of a pool of qualified physicians for military purposes. The functions of this office will be carried out with the thought always in mind of protecting the health of military and civilian population and the conserving to the fullest extent the medical resources available to the country. The Committee recommends the approval of this report.

DOCTOR MADSEN: I second the motion.

VICE-SPEAKER ASKEY: You have heard the motion and the discussion of the motion. If not, all in favor of approving this report say, "Aye," opposed, "No." It is accepted.

Report of the President-Elect:

The President-Elect of the California Medical Association serves, as it were, an apprenticeship in preparation for the real job the following year. . . . The Committee recommends approval of this report.

VICE-SPEAKER ASKEY: I understand that you move the acceptance of Report, Doctor O'Neill. Is there a second to Doctor O'Neill's motion.

DOCTOR DOYLE, Los Angeles: I second the motion.

VICE-SPEAKER ASKEY: Seconded by Doctor Doyle of Los Angeles. Is it accepted? All in favor say, "Aye," opposed, "No." The report is adopted.

Report of the Speaker of the House of Delegates:

The California Medical Association and its House of Delegates will convene this year under the extraordinary circumstances attending war. . . . The Committee recommends the approval of this report.

VICE-SPEAKER ASKEY: . . . The report is adopted.

Report of the Vice-Speaker:

This year has been one of activity for all the Officers of the Association. Our Vice-Speaker has attended by invitation many of the meetings of the Council and has followed the proceedings closely. He has found our Officers to be alert, earnest, and conscientious in all of their actions. The Committee recommends the approval of this portion of the report. . . . The report is adopted.

Report on the Chairman of the Council:

The Council submitted in the Pre-Convention Bulletin a tentative report. At Del Monte an additional report is made. . . .

VICE-SPEAKER ASKEY: . . . This section of the report is adopted.

Report of the President of the Trustees of the California Medical Association:

The Financial Report of the Trustees of the California Medical Association is printed in the Pre-Convention Bulletin as a self-explanatory statement. The non-Profit Corporation Trustees of the California Medical Association has, as its members for the year, the general Officers and the Councilors of the Association of that year. The Corporation, in accordance with the corporate laws of the State, meet as the custodian of endowment and special funds that may be transferred to it for custodial supervision and care. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: . . . This section of the report is adopted.

Report of the Legal Department:

. . . This Report, among other things, sets forth the

* The reports here discussed appeared in the April issue of CALIFORNIA AND WESTERN MEDICINE "Pre-Convention Bulletin" supplement, on pages 200 to 226. In the minutes as here printed, whether or not stated, the Pre-Convention Reports were accepted and adopted, unless otherwise noted.

legal aspects of the more important legislative bills affecting medicine which became law at the last session and legislative work in preparation for the next. . . . The Supplementary Report by our General Council, dealing with the infiltration of State Medicine through many Executive and Administrative Agencies of the Federal Government, should receive our thoughtful consideration. The Committee recommends the approval of this section of the report.

VICE-SPEAKER ASKEY: . . . This section of the report is adopted.

Report of the Editor:

At the last annual session, the House of Delegates authorized the appointment by the Council of an Editorial Board of thirty members, consisting of representatives of fourteen specialty groups with an Executive Committee. During the past year, under the new arrangement, manuscripts have been referred to various Board members for opinions and suggestions. . . . During the last year, consequently, in order to hold down the printing cost, the issues have been limited to 96 pages, of which 56 pages were available for text material, divided between articles dealing with scientific and organized medicine. Also, in order to produce a publication at less cost than formerly, a change of printer was authorized by Council. The first issue, under the new arrangement with the printing done in Los Angeles and the Editorial Offices in San Francisco, appeared in January, 1942. Before judgment is passed on the set-up, it will be necessary to bring off from the press at least five or six issues. In the meantime, every effort is being made to produce a publication that will measure up to the typographical standards of former years. The new procedure threw much extra work on the Editorial Office, since the interchange by mail, instead of by direct messenger contact, naturally makes for a certain amount of delay. During this transition period, therefore, the contributors are requested to make due allowance. Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: . . . This portion of the report is adopted.

Report of the Executive Committee:

The Executive Committee has had very little call on its services in the past year. . . .

VICE-SPEAKER ASKEY: . . . This portion is adopted.

Report of the Auditing Committee:

The Auditing Committee has performed the functions laid down in the by-laws. The professional audit of the Association books by the Certified Public Accountants showed them to have been accurately kept and the Committee has submitted its recommendation for the 1943 Budget. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: . . . The section is adopted.

Report on Associated Societies and Technical Groups:

In their separate localities, whenever possible, they have the aid of the Woman's Auxiliary, the Nurses' Association, and the Technician and Hospital Groups. . . .

Report of the Committee on Health and Public Instruction:

The individual members of the Committee have all been actively engaged in Civilian Defense Programs in their various localities. . . .

Report on Histories and Obituaries:

The Committee on Histories has made plans to proceed with collection of historical data, and is happy to an-

nounce that it has secured from relatives in Georgia a copy of the painting of a founder of the Medical Society of the State of California—now the California Medical Association—the late Benjamin Franklin Keene. The painting will be given a place of honor in the Association offices, and is now on display in the lower corridor of the Hotel Del Monte. The County Medical Societies are again urged to appoint Committees with responsibility to gather for a record book for future use the compilation of history of their respective units. A list of members who died during the year 1941 numbers 70 more. . . .

Report on Hospitals, Clinics, and Dispensaries:

This report indicates that during the year 1942 a great percentage of the private practice of medicine in the County of Los Angeles may be supplemented by socialized medicine, and the Committee suggests three plans of action:

(1) A new appropriation bill is being enacted by Congress at the present time, providing another 150 million dollars for assisting non-profit public and private hospitals, and other public facilities. We should organize a plan to secure some of these funds for the private hospitals in the State of California.

(2) We should set up a plan for tabulating and clearing all private patients who need hospitalization and are unable to secure it in private hospitals. Some methods should be devised for taking care of these patients so that they are not forced to go to the County Hospital.

(3) A plan should be devised and recommended to each physician so that all borderline private patients who cannot pay both private hospital and physician are referred to the County Hospital; thus, leaving the beds in the private hospitals for the patients who can pay both physician and hospital. In other words, if we must force patients to go to the County Hospital, let us force the indigent patient to accept these facilities. The Committee recommends that the State Medical Society consider the problem of hospitalization as one of their main objectives during the first part of 1942. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: The Committee moves the adoption of this portion of the report. Is there a second?

DOCTOR DEWEY: I second the motion.

VICE-SPEAKER ASKEY: Seconded by Doctor Dewey of Pasadena. All in favor say, "Aye," opposed, "No." Doctor Halley wishes to discuss this section of the report. The question has not been taken yet.

Discussion:

DOCTOR HALLEY, San Joaquin: Relative to the first recommendation, "a new appropriation bill is being enacted by Congress at the present time providing another 150 million dollars for assisting non-profit private and public hospitals and other public facilities. We should organize a plan to secure some of these funds for private hospitals in the State of California." I think that carries implications which perhaps this House of Delegates would not like to officially approve. I attempted to take this up with the Committee, but since there was a criss-cross between two activities by the same Chairman, he felt that it should be brought forward here. This item may be presented. The Federal services (United States Civil Service Employees' Compensation Commission), of whom there are a great many members appearing around the State in these Army Post activities and so forth, are being forced into private hospitals at \$3.75 a day.

I doubt if any hospital, certainly very few, operate their ordinary service facilities without taking into consideration the overhead, repair, deterioration, etc. Now, if these hospitals, under our encouragement, are put into the position of accepting grants or loans, their bargain-

ing power in connection with that item is reduced. Having lost the effectiveness of their bargaining power, it is only a matter of time until the mounting deficits from operating at below cost will put them directly back into Uncle Sam's hands. And perhaps we will lose the thing we are trying to save. The other implication is that, if we approve a plan to go after these funds on behalf of the hospitals, many of our friendly enemies in the Federal Services will take this official action and misinterpret it to their own benefit.

Therefore, Mr. Speaker, I move the deletion of the first subdivision concerning the new appropriation bill, etc., and through "we should organize a plan to secure some of these funds for the private hospitals in the State of California."

VICE-SPEAKER ASKEY: Your motion is an amendment to the motion to adopt the portion of the report. Is there a second to the motion?

DOCTOR DOUGHTY: I second the motion.

VICE-SPEAKER ASKEY: The motion is to strike the words referred to from this section of the report. Doctor Green.

DOCTOR GREEN: I wish to take the opposite side in this discussion. In my own experience, in a concrete instance in Vallejo, the Government offered a subsidy to our hospital, which has only 78 beds, of \$150,000. The private owner and manager of this hospital, being a gentleman of some 82 years, decided that he did not want to have anything to do with it. So consequently to date we still have 78 beds. Now, that forced us into the position, not being able to have a private hospital, of having a public hospital. So, with those few words, I want to commend Doctor O'Neill's recommendation.

VICE-SPEAKER ASKEY: Is there further discussion on this amendment to the motion? Doctor Doughty.

DOCTOR DOUGHTY: Mr. Speaker, I think Doctor Green misinterprets Doctor Halley's motion. His intentions deal with cutting out the reference to appropriations. Dr. Halley does not wish our antagonists to quote from our minutes and be able to state that we have approved their plans and so permit them to use such a statement as propaganda for Federal Socialized Medicine. He is not opposed to the policy, but he is opposed to putting it down in black and white, because he thinks it might be misused for propaganda.

VICE-SPEAKER ASKEY: Is the purpose of the amendment understood? Is there further question or discussion?

DOCTOR GREEN: The question is, sir, how to get hospital beds?

DOCTOR HALLEY: The point is more whether the Committee of the California Medical Association should officially support the program, not how to get hospital beds.

VICE-SPEAKER ASKEY: There seems to be a disagreement, not as to what is to be done, but as to how to do it, and that is the purpose of the amendment as I see it. Is there further discussion? Doctor Ward.

DOCTOR WARD: I wonder if approval of the California Medical Association would affect the decision of the 78-year-old manager of this hospital.

DOCTOR SHEPHARD: I think this question comes right down the alley of the Committee which was appointed last year, of which I was Chairman, in regard to hospitalization subsidy. To the few of you who have been following the trend of the Government in an attempt to force State medicine down our throats, and particularly those of you who have followed the report of the Social Security Board, cannot help but realize that we not only have State medicine as a threat against us, but that it is already here to a large extent. Last year, over 50 per cent of the patient days in the State of Califor-

nia were spent in tax-supported hospitals. After this War is over, it takes no crystal gazer to realize that there will be a great many more citizens hospitalized at Government expense. To me it seems that this is the first opportunity that is offered us to segregate, or to trade with the Government, and preserve for us the private practice of medicine; whereas the hospitalization problem is going to be taken care of out of taxation. You will remember, also, that the Social Security Board in a recent recommendation, which is not incorporated in its annual report, does recommend that they all come under Social Security Benefit, of which there are some thirty million at the present time and will receive a subsidy for hospitalization, tentatively recommended by the Social Security Board, of about \$3 per day. If we can get our hospitalization taken care of through some form of compulsory hospital insurance, which means tax-supported institutions, then you and I and the rest of the doctors in the country will administer medical care, and in that way we will save for ourselves the private practice of medicine; whereas hospitalization can become, and probably will become, a State and Federal job. I believe that if the Federal Government is willing to enter in to the establishment of hospital beds, and we will get behind the program and will direct the matter in which this is to be put into operation, we can save for ourselves the private practice of medicine. Now let's go back into history just a little bit. There are some of you men here from Los Angeles who were active in the practice of medicine at the time the California Employers' Act was passed, the State Compensation Bill. If I am correctly informed, the Los Angeles County Society at that time were so strongly opposed to any form of Compensation Insurance that, by resolution or by modification of their by-laws, any member of the Los Angeles County Medical Society that indulged in compensation practice would be deprived of his membership in the Los Angeles County Medical Society. If I am in error in my statement, please correct me. At least that is what I have been very definitely informed. In other words, at the time that the Compensation Bill was passed, there was no coöperation nor directing influence through the medical profession; consequently, we had choked down our throats the thing which none of us have been particularly fond of. I believe that, if we are going to direct the course, we have got to lend a helping hand and by so doing, perhaps, and only perhaps, we may be able to save the one thing in the practice of medicine which you and I want and that is the medical service.

VICE-SPEAKER ASKEY: Is there any further discussion? Doctor Pallette.

DOCTOR PALLETTE: Gentlemen, I would like to put Doctor Shephard right on his statement in regard to the Los Angeles County action in regard to the State Compensation Act. In the first place, the action was not taken at all, because it was voted down, and the action was merely attempted because the men who made the motion and were supporting it objected to the Fee Schedule as being too low and not objecting to the principle itself. Now, if I may speak on the motion to delete. . . . I support the motion to delete.

VICE-SPEAKER ASKEY: Further discussion? Doctor Madeley of Solano.

DOCTOR MADELEY: I think what I am going to say is probably something that everyone knows, but I don't think Government subsidy of hospitals is going to help the medical profession. The Government doesn't invest money and not look after the money it invests. If the Government is going to build hospitals and provide hospital beds, it is going to run them after they have built them. I think that if we allow them to build hospitals, and provide beds for our civilians, it will put

them under complete Government subsidy, and not aid the private practice of medicine. I support the deletion motion of Doctor Halley.

VICE-SPEAKER ASKEY: Doctor Carr of San Francisco.

DOCTOR CARR: After the last address, gentlemen, this is redundant, I know, but it appeals to us that this is an insidious move; that it is an infiltration project whereby the Government does seek to control the practice of medicine. If you look over the Government hospitals of which we are conscious at present, you will find that they do not control the hospitalization, excepting by controlling the practice of medicine. It is my feeling that this so-called helping hand which we are about to extend is going to return to us as a hot hand in the seat of our pants, and I think we had better avoid it. (Applause.)

VICE-SPEAKER ASKEY: Doctor Hope, do you wish to discuss it?

DOCTOR HOPE: I think one little point might be brought out, that in C.P.S.'s negotiations back in Washington in the setting up of the Linda Vista project, during the course of the talks, one of the arguments brought out by individuals who are very strongly interested in setting up Government Bureaus for caring for these projects and extending into other projects for the fact that medical care could be given at a cheaper rate if the overhead was brought down. I think that the compulsory hospital insurance with Government-run hospitals would be the first step to amalgamating the clinics that were set up in cutting down that overhead and I think it is an insidious step. There is a very definite trend of thought along that line. I don't believe that a complete subsidy would help it.

DOCTOR ROGERS: I simply want to call to your attention how the funds have already been expended in California. I think at the present time this 150 million dollars, previously referred to, has been increased to 375 million. The Committee from Washington, which visited California, inspected a lot of hospitals, and put several hundred beds in Los Angeles General Hospital with the provision that they must accept their patients. I think they put 100 beds in the Solano Hospital, didn't they, with the provision that we must accept their patients. This money in a big majority of cases is going into the already tax-supported hospitals, with the stipulation that the hospitals must accept their patients. . . .

VICS-SPEAKER ASKEY: Doctor Green.

DOCTOR GREEN: I wish to say this, that under ordinary circumstances before war was declared I would agree with that entirely, absolutely. I thought that thing before, but now we have a war and now we have places where we must have hospitals. They offered our hospital 150 thousand dollars to increase its facilities a year ago for our purposes. The managers, I say, and owners refused, so consequently even now in this emergency we have no beds. We have to find beds for our patients in a hospital somewhere around the Bay District, but had we been smart or had we been able to prevail upon that owner and manager to accept the proposal, we would now have some private beds, even though through Government subsidy. But now, we have been struggling to find beds for patients for six months. We still have no beds, but when we do get a hospital, it will be a city hospital, owned by the Government, run by the Government, through the city as administrator, and we won't have a thing to do with it except to staff it.

VICE-SPEAKER ASKEY: Doctor Sharpe of Monterey County.

DOCTOR SHARPE: Mr. Speaker, Mr. Chairman, Members of the House of Delegates: I had a little experience with this situation. About a year ago, we were faced in Monterey County with the problem

of the hospitalization of the dependents of many of the enlisted personnel in the Army. We were asked in the County Hospital if we could and would take care of these people. We did not have the facilities; therefore, when the Flanham Act was passed, we made application for a grant, primarily for maternity beds and for isolation. To date we haven't seen any of the money. Now, the application for our grant was sent forward in June. Since then, we have had a changing picture in our community, in that we have not had the need for these beds, because the change in the military establishment, has not brought the dependents upon us. However, the Government came to us and still wished to proceed with giving us the grant on the stipulation that we accept pay patients. And in our community, we felt that we would not be the Government's guinea pigs of the State of California, because the State law did not permit us to accept pay patients. That being the situation, we could not proceed on that basis.

Now if anyone reads the original act which provided the first 150 million dollars, there is a section that says that the Government shall have nothing to do with the personnel, the administrative policies, the management, or anything else in the institution. Nevertheless, we have been informed that, despite the provisions of the act, we should and could accept some such patients. We were given a grant, but nothing has happened and nothing has been built. We need more hospital beds in our community. In a certain portion of Monterey County there is an acute need for private hospital beds, and on that basis a hospital project was sponsored and a certain amount of money was raised, insufficient however, to provide the required number of beds. I believe that an application is before the Federal Government at this time for funds to complete that project. If such goes through under the terms of the present act, I do not see how there can be any regulation of the institution, the management, or its policies. In any supplementary bill, the act may be changed and there might be an opportunity for such interference in the management of the institution, but in the act passed so far, if the letter of the law is adhered to, there can be no interference.

VICE-SPEAKER ASKEY: Is there further discussion on this amendment to the motion? The question will be upon the amendment to the motion which is to delete a part of the report given by Doctor O'Neill. All in favor of the amendment say, "Aye," opposed, "No." We will have a standing vote, please. All in favor of the amendment please stand. Opposed please rise. The amendment is carried.

The question now comes from the motion as amended. This is sort of a paradoxical thing because the motion was to accept it where the amendment was to delete it, so in order to carry your amendment, you must pass the motion. Is that understood? In other words, the motion has been amended. If you wish the amendment to be carried, the motion must be carried even though it states the opposite from the amendment. Is that correct, Mr. Speaker?

SPEAKER GOIN: Just part of the motion was amended.

VICE-SPEAKER ASKEY: I mean, the motion as deleted. All in favor of the motion as amended say, "Aye," opposed, "No." The motion is amended. Mr. Chairman would you proceed with the report.

Report of the Committee on Industrial Practice:

The questionnaires submitted by the American Medical Association have been completed as much as possible and your Committee has furnished the Federal Government through the American Medical Association Headquarters with lists of all of those in the State who have practiced industrial surgery and have given their qualifications as rendered in the forms submitted.

The Committee believes that it would be advisable to have a qualified industrial hygienist on this Committee. The Committee recommends the approval of this portion of the report.

Report of the Committee on Medical Economics:

The past year has not produced any marked trend in medical economics. The California Physicians' Service has quietly put into force contracts which most certainly will prove to be very far-reaching in the effect on the threat of State medicine if the profession will continue to give it full support. The Committee recommends the adoption of this portion of the report. . . .

VICE-SPEAKER ASKEY: It is adopted.

Report of Committee on Medical Education and Medical Institutions:

It is interesting to report that each of the four medical schools in California has adopted as a war emergency measure a program of medical education by eliminating the long summer vacations and scheduling their courses, ordinarily given during four calendar years in a continuous manner, so that classes entering in the summer of 1942 will graduate in three calendar years. The Committee recommends the approval of this portion of this report.

This section of the report is adopted.

Report of Committee on Membership and Organization:

The Committee on Membership and Organization has held no meetings and conducted no activities, largely because of the efficient management of the Association's Central Office. . . .

VICE-SPEAKER ASKEY: This section is adopted.

Report of the Committee on Postgraduate Activities:

It is the hope of the Committee that, with the coöperation of members of the Armed Forces, staff members of the Medical Schools in the State, and other physicians informed in regard to these matters, programs having to do in particular with treatment of fractures, treatment of burns, treatment of gas casualties, and treatment of acute emergency such as shock, and hemorrhage may be brought before many of the County Societies throughout the State. This program is being developed at the present time. Fourteen postgraduate conferences were held during the year 1941. The Committee recommends the approval of this portion of the report.

This section is adopted.

Report of Committee on Public Policy and Legislation:

The closing week of the Legislature found the Legislative Committee very busy. During the entire 1941 session, there were 4,381 bills introduced; of this number 376 had some reference to Public Health. Perhaps the Bill which caused the Committee the greatest activity was the AB1475 reference to alien doctors. This Bill was vetoed by the Governor. For the first time this Committee attempted to pass a bill over the Governor's veto. It succeeded in doing this because of the intelligent and persistent generalship of Assemblyman Roger B. Pfaff. (Applause.)

In January, 1942, the Governor called a special meeting of the Legislature for the purpose of considering the State Guard Bill. Since the Adjutant General had previously appointed a man to fill a very important position in the Medical Department of the California State Guard, it was deemed advisable to have the qualifications of the medical officers made clear. The Committee was able to do this by stating in the Bill, which was

passed by the Legislature, that medical officers of the State Guard should have the same qualifications as those of the Army and Navy. It was further specified in the Bill that any medical officer in the service whose qualifications did not meet with these regulations should be dropped at once. The Committee considers this an important piece of legislation and was very happy to secure its passage.

An informal conference was also held with representatives of the labor groups. This conference was requested in an effort to learn what were the wishes of organized labor regarding the care of citizens coming under the provisions of the California Industrial Accident Law. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: This section of the report is adopted.

Report of the Committee on Public Relations:

This Committee has had no meetings during the past year. This Committee feels that the field of Public Relations should include the education of our own members of the California Medical Association to a better understanding of the work being accomplished by the Head Office, by the Council, and by the House of Delegates. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: Is there a discussion on this? If not, all in favor say, "Aye," opposed, "No." This section of the report is adopted.

Report of the Cancer Commission:

The Commission wishes to report that all meetings which it sponsored during the past year have been most successful. The clinical session at the last State meeting was attended by about 300 persons and was a most excellent meeting. The members of the Cancer Commission have continued to act as the Executive Committee for the Women's Field Army of the American Society for the Control of Cancer. The Committee recommends the approval of this section of the report.

VICE-SPEAKER ASKEY: It is carried.

Report of the Committee on Public Health Education:

The principle project for the year was an assignment to this Committee by the Council for promotion of the campaign for securing signatures to place the basic science on the ballot. This proposed initiative was given to the Committee by the Council after it had been drafted by the Public Relations Committee, and after it had been approved by allied groups through the efforts of that Committee. The Committee on Public Health Education, at its February meeting, outlined the instructions which accompanied the petitions, and financed and oversaw the preliminary distribution of the initiative petitions to physicians, dentists, nurses, opticians, and druggists. This work was done at a total cost to the Committee of \$2,500, and to date has brought in about 90,000 signatures of the required 312,000 gross.

A new undertaking on the part of the Committee this year was that of exhibiting at the various County Fairs. At the May meeting, the Committee earmarked \$1,000 to pay cartage on the exhibits to and from the places where County Fairs were held, and so it was possible, during 1941, to exhibit at 13 County Fairs. This was accomplished primarily through the efforts and coöperation of our Secretary, Doctor George H. Kress. The Committee recommends the approval of this portion of the report. . . .

VICE-SPEAKER ASKEY: Is there a discussion? Doctor Makinson.

Discussion:

DOCTOR MAKINSON: I think the report of this Com-

mittee should be revised and brought up to date. I would like to ask permission to bring Mr. Ben Read, Secretary of the California Public Health League, to the microphone, to fully explain these very recent developments.

VICE-SPEAKER ASKEY: To hear Mr. Read speak requires the unanimous consent of this House. Is there objection to hearing Mr. Ben Read speak as requested by Doctor Makinson? Mr. Read, you are invited to discuss this problem before the House of Delegates. Doctor Makinson will introduce Mr. Read.

DOCTOR MAKINSON: It gives me very great pleasure to present Mr. Ben Read. . . .

MR. BEN READ: As a result of the efforts of the members of the profession, we secured a total of 107,000 signatures. Now, that was considerable less than the figures that were quoted around the room very openly at the Coronado meeting, as some of you will recall. We were going to have several hundred thousand signatures within a few weeks and after several months we secured 107,000 with the efforts of the profession and we thought that was pretty good. We do appreciate your coöperation. The Committee then employed a group of professional circulators to complete the job. It requires 212,117 valid signatures to place this on the ballot. And, we now have in view the required number, that means a gross of around 300,000. And we have those in sight, in fact we have the job completed, as we could file the petition tomorrow, if necessary. However, a few weeks ago the chiropractors in an effort to oppose this brought up a sort of a phony initiative proposition, and they have the title of "Basic Subject Act." It has three or four high school subjects in it, and the entire purpose is to confuse the public and defeat the Basic Science Initiative. Now, they have employed another group of professional solicitors to secure their required signatures. The job must be done in rather short order, as June 5 is the closing date for securing their required number of signatures. We rather doubt if they have any desire to get this before the people and pass it. They simply want to kill your Basic Science Initiative. As one of their methods, you may have noticed that Doctor Kress, in your CALIFORNIA AND WESTERN MEDICINE, reproduced letters sent to all chiropractors in the State, in which they were told to contribute the amount of \$100 each, or their license would be endangered by the State Chiropractor Board. . . . So, we are confronted with a campaign of meeting that opposition that is now in the field. I can't, for obvious reasons I believe that you will all understand, give in a public meeting the details of that campaign. The Committee understands it, the Council has approved it, and we are proceeding along the lines that we believe will result in ultimate success. The matter is now in the hands of the Committee, and with the approval of the Executive Committee the outcome will be known within the next few weeks. We are doing the best that we can, to see that the opposition is defeated, and that your wishes are carried through to success. Again we wish to thank all of you for your efforts. A lot of you worked hard. I have one Doctor, who got over 800 names; then, we have others who got none, and some, of course, many. We thank those who coöperated and within a few weeks you will know definitely what the future campaign is. (Applause.)

VICE-SPEAKER ASKEY: Thank you, Mr. Read. Doctor Makinson. . . .

VICE-SPEAKER ASKEY: This question is one of great importance because of the factors involved. My advice to you, and I think the advice of all, would be to look at these letters in the CALIFORNIA AND WESTERN MEDICINE and see what your opposition is ready to do. I think you will then comprehend the importance of this, and I am sure that if we inform ourselves, and follow Ben

Read's direction, and after his demands on our time and help, that everything will be well. Now, is the further discussion? If not, all in favor say, "Aye," opposed, "No." It is carried. Dr. O'Neill, will you finish?

Report of Committee on Physicians' Benevolence:

The Council of the California Medical Association, at its meeting of January 17, 1942, adopted the recommendations of this Committee providing for methods for distributing (a) the appointment of each County Medical Society of Physicians' Benevolence Committee, (b) auditing of the funds, (c) change of the name of this Committee, (d) and other matters required to enable this Committee to function and furnish some measure of relief to our needy. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: This section is adopted.

Report of the Editorial Board:

It was recommended that, in lieu of publishing all the papers that could be printed in the OFFICIAL JOURNAL or making selection therefrom, henceforth, beginning with this meeting of the California Medical Association, a special edition in the form of a supplement to the California Medical Association JOURNAL be published, in which be included a digest of every paper read at the State meeting. It was recommended that a section of the JOURNAL be set up which would appear from month to month with a review of the latest literature and discoveries in the field of medicine. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: The Chairman moves this section of the report be adopted. Is there a second? Doctor Kneeshaw.

Discussion:

DOCTOR KNEESHAW: Mr. Chairman, I have been informed that Chairman Lee of the Editorial Board who is now in the service, made that suggestion, about abstracts of all annual session papers, as outlined in his Pre-Convention Bulletin report, without consulting the rest of the Executive Committee, and I have been informed that at the annual Board meeting held on Sunday, May 3rd, the Board Members present agreed that the plan could not be carried out in a successful manner. I believe that there should be a deletion of that portion of the report which calls for the special edition, and I move such amendment of that report.

VICE-SPEAKER ASKEY: Is there further discussion? Doctor Walker.

DOCTOR WALKER: Doctor Russell Lee suggested this and there was much discussion at our Sunday meeting, of the plan to publish a digest of one column each, of all the papers read before the Annual Session. It was the consensus of opinion, by all present that while that might be desirable for some reasons, there were other reasons why it was not a practical procedure. The issue would be a hodge-podge of incomplete abstracts. We think it would not work well and for that reason the Editorial Board Members on Sunday last were unanimous in wishing to leave this out.

The other part of the report refers to the contributions to editorials for the Editorial Comment department as mentioned by Doctor Lee. We were all heartily in accord with that.

Then, a desire to have someone abstract from various articles published. That met with favor, if good abstracts could be obtained. Possibly, if each Section could furnish someone to abstract articles concerning the respective Section, it would be highly desirable. Therefore, to one part of Doctor Lee's articles we were opposed but to the other two recommendations we were heartily in accord.

VICE-SPEAKER ASKEY: Doctor Wilbur.

DOCTOR WILBUR: As a newly appointed member and Chairman of the Executive Committee of the Editorial Board, I should like to point out certain advantages of this particular method of Doctor Lee's of reporting the proceedings of the papers given at the State meeting. Those of you who are members of certain national associations will recall that special journals reporting those proceedings do print abstracts of all papers usually within a period of a few months after the meeting is held. It is to a great advantage of those who are unable to attend the meeting, or if they are, to hear all the papers given. You will also recall in the *Journal of the American Medical Association* there is published the abstract proceedings of the Central Society for Clinical Research, which proceedings the *Journal of the American Medical Association* considers sufficiently important to publish in that Journal. May I also point to another advantage? And that is by having such a supplementary number of abstracts, it is possible to bring before the profession in a relatively short period of time all the material which is presented before the Scientific Sessions of the State meeting. This will overcome the present situation in which some papers never reach the light of day in the *State Journal* and others require a period of at least eight months or a year before appearing in the JOURNAL. For those authors who wish to make a very brief abstract, this abstract may be included in such a supplement. For those papers which are of particular merit, the Editorial Board can consider whether or not they should be published in full in the JOURNAL. I, therefore, would like to urge that this particular provision of the Committee's report be included and not deleted.

VICE-SPEAKER ASKEY: Is there further discussion on this? Is there an estimate that could be made on this, Doctor Kress?

SECRETARY KRESS: The cost of the JOURNAL is under the jurisdiction of the Executive Secretary, Mr. Hunton. He will be able to give you approximate figures concerning costs. It would depend on the size of the signature or number of extra pages. We print ordinarily in group forms of 4, 8, 16, 32, 64 pages. I think we would need at least a 64-page form to include the abstracts of 150 manuscripts, provided it would be possible to secure such.

VICE-SPEAKER ASKEY: Mr. Hunton, can you be of help to us?

MR. HUNTON: It is impossible to estimate it accurately because of the fact that the composition of mechanical words as a supplement would not be comparable with mechanical words incurred in printing the regular issues of the JOURNAL. It would be my estimate that the supplement would cost in the neighborhood of \$1,500.

VICE-SPEAKER ASKEY: Does that answer your question, Doctor? Is there further discussion?

UNIDENTIFIED: Could this supplement be combined with the program so that the abstract would be ahead of the meeting rather than behind? Would that cut down the costs?

VICE-SPEAKER ASKEY: Doctor Kress, could you answer that question? The question is, "Could an abstract be given with the program, the Pre-Convention program, to obviate the necessity for this publication."

SECRETARY KRESS: Mr. Speaker, if you printed in advance, digests of one column length, of all papers read at an annual session, you would take away not only the interest in but value of many papers. Our fifty word abstracts in the Pre-Convention Bulletin permit our members to acquaint themselves in advance of the nature of each paper to be read. But to do more than that prior to the annual session would be detrimental to the

best interests of the essayists and the OFFICIAL JOURNAL.

VICE-SPEAKER ASKEY: Is it the understanding of this House that the abstracting and the inclusion of any such material that might be used would still be under the jurisdiction of our Editorial Board. I think that that is quite evident. Is there further discussion? All in favor say, "Aye," opposed, "No." I'll call for a rising vote. All in favor, please stand. The question is on the inclusion of this section of the report, which establishes a special supplement to be issued after the Convention, including abstracts of the papers, and such other abstracts as the Editorial Board shall deem wise. It will be estimated at a cost of about \$1,500 or thereabouts. Is there any other question before the question is put? All in favor, please stand. Dr. O'Neill's motion is lost. That section is not adopted.

1 1 1

Report of the Committee on Local Arrangements:

This beautiful auditorium and lecture rooms in which you are now seated here in Del Monte bespeak the interest and the coöperation shown by the Committee on Scientific Program and Local Arrangements, and the hotel management. The credit of securing the full coöperation of the Fort Ord military authorities goes largely to Doctor Mast Wolfson of Monterey, Chairman of the Local Committee on Arrangements. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: This section is adopted. (Applause.)

1 1 1

Report of Delegates to the American Medical Association:

I am sure that the representation from California will always render a favorable account of themselves at the American Medical Association. Cleveland was the host to the American Medical Association in the year 1941. The House of Delegates which is the legislative and governing body of the National Association was in session four days, beginning June 2, 1941. All the members of the California delegation were present and took an active part in the proceedings. The House has twelve Reference Committees. On these, three of the California members were appointed. Our California delegation was requested by the California Medical Association to present the following resolutions:

- (1) Resolution requiring appointment of Committee to confer with Committees of hospital associations.
- (2) Resolution authorizing establishment of a Health Exhibit for the public at cities where annual sessions are held. The first of these was approved and adopted by the House. The second was referred to the Board of Trustees which after consideration, advised that such a plan was not practical, and that such exhibits were usually held in Convention city either prior to or following the Convention week. The highlight of the last A.M.A. session was the report of the Committees on Medical Preparedness and the establishment of the Procurement Agency which later was made a part of the national administration under the honorable Paul V. McNutt. A comprehensive report of the American Medical Association trial was presented to the House of Delegates by the Board of Trustees. It was voted to sustain the action of the Board of Trustees in appealing the verdict of guilty. California was honored in the election of Doctor Charles A. Dukes as Vice-President of the American Medical Association. This was a much deserved honor to our beloved colleague, whose recent passing has given us great sorrow. He had been a member of the House for several years and had endeared himself to all by his never-failing kindly manner, and his earnest devotion to the best in organized medicine. It is with deep regret, therefore, that the California dele-

gation will have to return to Atlantic City without the cheerful companionship of Doctor Dukes. The Committee recommends the approval of this portion of the report.

VICE-SPEAKER ASKEY: The section of the report is adopted.

* * *

Reports of the Committee on Scientific Work and Section Secretaries:

The tentative scientific program outlined last summer by the California Medical Association Committee on Scientific Work and Section Secretaries underwent a radical change with the onset of war in December. It was then decided that military medicine and surgery should be stressed, and in order to conserve time of members, the general and section meetings on Thursdays would be omitted. An additional general meeting was secured for the allocation for Tuesday afternoon for that purpose. The military features of a program will be emphasized by the exhibit of the First Medical Regiment of the United States Army obtained through the coöperation of the medical officers at Fort Ord. All members in attendance should visit the tents which will be set up adjacent to the Convention Pavilion. The Committee recommends the adoption of this section of the report.

VICE-SPEAKER ASKEY: This section is adopted.

* * *

DOCTOR O'NEILL: At this evening's meeting, a report was handed to me by Doctor Garland on the *Committee on Medical Defense*.

VICE-SPEAKER ASKEY: If it is part of a report to your Committee, it is submissible.

DOCTOR O'NEILL: It is a part of a report to our Committee. Committee on Medical Defense. The Committee on Medical Defense did not render a formal report in the Pre-Convention Bulletin. However, members have brought to our attention the following information, much of which has appeared already in the Bulletin of the Los Angeles County Medical Association. The report concerns:

(1) The experience of insurance companies in the medical mal practice field has been poor.

(2) It is desirable that support be given to any American company of adequate size, stability, and experience, furnishing approved policies in this field.

(3) Such a company is operating in some parts of the State. The essentials of this program are the

(a) careful selection of risks, confined to members of the organized medical profession,

(b) handling of claims by the carrier in coöperation with the Committee on Medical Defense, and

(c) maintenance of records available to the medical profession for purposes of annual review, permitting determination of equity of premium charges. Your Committee recommends the approval of this report.

VICE-SPEAKER ASKEY: What is this report? Is it just a report to this body that there is available other insurance? Did you wish to speak, Doctor Garland?...

Discussion:

DOCTOR GARLAND: Mr. Speaker and Members: Doctor Nelson Howard asked me to prepare a thumb tack of a report dealing with this question, because he could not be here. He is the Chairman on the Standing Committee on Medical Defense. Now, this report represents the best opinion of Doctor Howard on this problem. It is not a recommendation of any one particular thing. It is just bringing your attention to certain facts which he believes are correct. I tried to get hold of the Reference Committee in question, so that this might be incorporated, in proper orthodox manner, in his report,

but I couldn't find the Committee until tonight at 5 o'clock and that is why it was brought out in this slightly irregular manner.

DOCTOR CLINE: I believe that this is correctly in the hands of the Committee, because it is merely a report and not a resolution. There seems to have been a little confusion concerning Doctor Howard's wishes in this matter. Apparently, Doctor Garland understood him one way. I understood him another way quite completely. This matter was presented for inquiry before the Council in my behalf the other day, and certain information came out as a result of the discussion at that time, which I think would make Doctor Howard's mind up in a different way than expressed in the report.

DOCTOR WILSON: I offer an amendment that the report be filed.

VICE-SPEAKER ASKEY: You have the motion to amend the motion so that the report be filed. Is there discussion on the amendment? All in favor of the amendment, which is to file this section of the report say, "Aye," opposed, "No." The amendment is carried. The motion is now before you. All in favor of the motion as amended say, "Aye," opposed, "No." The motion as amended is adopted and this will be filed.

DOCTOR O'NEILL: Mr. Speaker, I move that my report as amended be approved.

DOCTOR FLETCHER: I second the motion.

VICE-SPEAKER ASKEY: Doctor Alesen.

DOCTOR ALESEN: Do I understand, sir, that the special report of our Council dealing with bureaus and commissions, and pointing out pernicious effect before our economic body, is also included?

VICE-SPEAKER ASKEY: Was that in your report, Doctor O'Neill?

DOCTOR O'NEILL: That was not in my report.

VICE-SPEAKER ASKEY: . . . Question is on the adoption of the Report of Reference Committee No. 1, as presented by the Chairman, as amended and as a whole. Is there further discussion? All in favor of the adoption of the Report of Reference Committee No. 1, as amended say, "Aye," opposed, "No." The report is adopted.

At this time I wish to state to you, as you all know that I have been your Chairman by the kind indulgence of your real Speaker, that at this time I will return to him the gavel. (Applause.)

* * *

REPORT OF REFERENCE COMMITTEE NO. 2

SPEAKER GOIN: Reference Committee No. 2 for the purpose of receiving the report of that Committee, the Chair recognizes its Chairman, Doctor L. Henry Garland, of San Francisco.

DOCTOR GARLAND: Mr. Speaker and Members of the House: I have a very slim report to present to you:

The Report of the Council:

(a) as printed in the Pre-Convention Bulletin. The Committee has reviewed this report and recommends its adoption. . . . The motion is carried.

DOCTOR GARLAND: (b) the *Additions to the Report of the Council* as presented to the first session of the House,* the following addition has been reviewed and the Committee recommends its adoption:

Concerning C.P.S. Resolution of Council of Alameda County Medical Association:

WHEREAS, The Council of the Alameda County Medical Association has by Resolution advised the Members of said Association to resign as professional Members of the California Physicians' Service; and

WHEREAS, The Council of the California Medical Association, at a meeting held May 3, 1942, duly resolved to

* See New Item 1 on page 61.

present to the Alameda County Medical Association the following question, "Will the Members of the Council of the Alameda County Medical Association, on behalf of its membership and for the benefit of medicine and the good of the profession in California, subjugate their personal opinions to the opinion of the majority of their fellows of the California Medical Association and rescind the Resolution above mentioned?" now, therefore, be it

Resolved, That the answer of the Council of the Alameda County Medical Association, to said question, may be deferred for a period not to exceed thirty days, and within that time the Alameda County Medical Association must submit a definite answer in writing to the foregoing question submitted to it.

Mr. Speaker, I move the adoption of this portion of the report.

DOCTOR MURRAY: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." The motion is adopted.

* * *

Concerning Sacramento Society for Medical Improvement:

DOCTOR GARLAND: In this connection your Reference Committee wishes to recommend that the Council of the California Medical Association take immediate action relative to the Sacramento Society for Medical Improvement, presenting to that Society a question analogous to that presented to the Alameda Medical Society, with the request for an answer within a similar period of time. The Committee respectfully draws attention of the delegates the fact that California Physicians' Service is not a County Society Problem. It is a state-wide State Association Problem, created by an overwhelming vote of the delegates of a previous House. As such, it is the duty of each component society of the State Association to support it in every manner possible until such time as the majority of this House recommends its dissolution. Irrespective of the merits of any program embarked upon by this Association, it is incumbent upon us as delegates and members of the Association to support that program. This is not only the very core of democracy, but it is a fundamental necessity for us as a survival as an independent profession.

Finally, in connection with the program of California Physicians' Service, it is our humble suggestion that the income ceiling for beneficiary members be gradually lowered to a figure substantially below the present maximum. Perhaps, \$1,800 per annum for individuals, and that a development of indemnification methods for persons above that income level be explored.

Mr. Speaker, I move the adoption of this section of the report.

DOCTOR HAYES: I second the motion.

SPEAKER GOIN: The motion is seconded by Doctor Hayes. Any discussion? Doctor MacDonald.

DOCTOR MACDONALD: In order to clarify the record, I would like the House of Delegates to know that in Sacramento some time ago, at least two years ago, a resolution was adopted regarding California Physicians' Service. At the request of the Council of the California Medical Association, that resolution was rescinded and at the present time, in Sacramento, there is nothing to prevent any individual member from joining California Physicians' Service.

SPEAKER GOIN: Any further discussion? If not, are you ready for the question? The question is on the adoption of this section of the Committee's report. All in favor say, "Aye," contrary, "No." The "Aye's" seem to have it, the "Aye's" have it, and this section is adopted.

* * *

Concerning Unit Values in California Physicians' Service:

DOCTOR GARLAND: The following addition to the Council Report has been reviewed and the Committee

recommends its adoption. A Committee of the Council has studied the question of hospitalization costs, and in connection with which it is believed that certain changes can be made which will result in raising the unit value. Mr. Speaker, I move the adoption of this portion of the report.

DOCTOR HALL: I second the motion.

SPEAKER GOIN: Seconded by Hall. Any discussion? Doctor Crosby of Alameda.

DOCTOR CROSBY: I would like to tell you two stories. . .

Now, there have been certain repercussions concerning medical service, gentlemen, that have caused a great deal of trouble, a great deal of anxiety and a great deal of friction, and a great deal of acrimony in the California Medical Association, and the difficulty lies in this: that people are paying too much attention to the repercussions and are not paying attention enough to the circumstances that laid the foundation for those repercussions. This change in the ceiling income of beneficiary members is a perfectly beautiful gesture, and it may help, but I think we have got to remember that we can't give too much attention to repercussions, and we have got to retrace a little bit and give our attention to the circumstances that are causing the actions that are producing those repercussions. (Applause.)

SPEAKER GOIN: Any further discussion? Doctor Lawson of Oakland.

Discussion:

DOCTOR LAWSON: I am speaking as a representative of one of the hospitalization organizations operating in California, the Hospital Service of California, with headquarters in Oakland, to give you one or two figures about hospitalization costs in the last three to five years. In the Guild Index of New York City which analyzes the hospital costs of all the hospitals in the United States, it is stated that from January 1, 1939 to January 1, 1942, the costs of the hospitals, as regards materials and supplies, have risen 35 per cent. As far as salaries are concerned, they have risen 10 per cent—a total cost of 45 per cent in the last two years. There is on foot in Washington legislative, a bill to deny taxation exemptions for all hospitals, both non-profit, or for profit, and, also to put an income tax on all hospitals and colleges. Also, we have a movement at Washington to include all hospital employees as far as Social Security taxes are concerned, which will mean an increase of 5 per cent of hospital employees' salaries and the employers to add 5 per cent. Your President-elect, Doctor Karl Schaupp, is a member of our Board of Directors and he has told very tritely what the hospitals do when this subject of hospital costs comes up. . . . At the present time, we must realize that respecting the hospitalization costs in the entire United States, they are the highest right here in California and the highest are in Alameda County. Our ward bed costs go from \$5.50, most \$6.00, and up, with the emphasis on the up, and if you think we are well organized, don't think we are as near well organized as are the hospital associations. They are telling us, gentlemen, where to head in. Practically, they say: "Take it or leave it. Our beds are occupied. We don't have to do as you say." The hospitals are telling the medical profession what to do. As far as hospitals being willing to take certain suggestions at the present time, with a boom on, they won't listen a second time. . . .

SPEAKER GOIN: Any further discussion? Question is on the adoption of this section of the report. All ready for the question? All in favor say, "Aye," contrary, "No." The "Aye's" have it. The section is adopted.

* * *

DOCTOR GARLAND: Part No. 2: *Report on the Secretary-Treasurer:*

The Committee recommends the adoption of the report

as printed, and in doing so it wishes to draw your attention the sound condition of the finances of the California Medical Association. It discloses the combined surplus as of December 31, 1941 as \$92,578.12. Some of this will, of course, be expended on the Basic Science Initiative during the current year. Further, our income has diminished considerably as a result of the remission of dues to members in the military service. In connection with future Reports of the Treasurer: the Committee respectfully suggests that these be simplified, and perhaps not reproduced entirely in the formidable manner customary with certified public accountants. Mr. Speaker, I move the adoption of this portion of the report.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Any discussion? If not, all in favor say, "Aye," contrary, "No." The motion is carried.

DOCTOR GARLAND: Part No. 3: *Report of the Executive Secretary:*

The Committee recommends the adoption of the report, as printed. Mr. Speaker, I move the adoption of this portion of the report.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: All in favor say, "Aye," contrary, "No." The motion is carried.

DOCTOR GARLAND: Mr. Speaker, I now move the adoption of the entire report. Motion is carried.

SPEAKER GOIN: . . . Reference Committee No. 3 is the Committee on Resolutions, Amendments of the Constitution and By-Laws, and Miscellaneous Business, with Doctor Dwight L. Wilbur, as Chairman.

CHAIRMAN WILBUR: May I ask, since this report is longer than that of the Chairman of the last Committee, that the House recess for a moment while mimeographed copies of our report are distributed among the members of the House. . . .

* * *

REPORT OF REFERENCE COMMITTEE NO. 3

CHAIRMAN WILBUR: Mr. Speaker, Members of the House of Delegates:

The members of this Reference Committee No. 3 are Doctors Dwight H. Murray, delegate of Napa County; Franklin Farman, delegate of Los Angeles County, and myself, of San Francisco County. Reference Committee No. 3 has met and had hearings on the proposed amendments to the Constitution, a proposed amendment to the By-Laws, Resolutions, Reports of Special Committees, and the Report of the Legal Department and wishes to report to you as follows:

(a) *Report of the Committee on Payments for Medical Services:*

It was reported that no amendment will be suggested, Mr. Peart, as legal counsel having informed the Committee that such could not lawfully be done. Your Committee approves the recommendation, and as Chairman, I move the adoption of this section of the report.

DOCTOR O'NEILL: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." This section of the report is adopted.

Report of the Committee to Survey California Medical Association Legal Department:

Regarding the verbal report given by Doctor Gilman, as Chairman of the special committee to survey California Medical Association Legal Department, the Reference Committee wishes to report that the House of Delegates having been informed that the survey of the Legal Department has been made with findings satisfactory to the Council, the Reference Committee recommends approval

by the House of Delegates. I hereby move adoption of this section of the report. . . . This section is adopted.

Report of Committee on Conference with California State Federation of Labor:

Regarding the report of the Committee on Conference with California State Federation of Labor, the Reference Committee wishes to report that the House of Delegates, having received an oral report by the Chairman, Doctor Cline, recommends that this Committee be continued to carry on its further duties and work. I move the adoption of this section of the report. . . . This section is adopted.

Report of the Committee on Pension Policy for Retired Employees:

A report of the Special Committee on Pension Policy for Retired Employees, prepared by Doctor Edward N. Ewer, Chairman, was submitted to your Reference Committee as a report to substitute for the one presented to the House of Delegates which substituted report reads as follows:

"In the matter of pensioning employees of the California Medical Association, your Committee recommends that the Council of the California Medical Association be authorized and directed to take such action as they may deem advisable from time to time." Your Committee approves this report. As Chairman, I move the adoption of the substituted report.

DOCTOR KIGER: I second the motion.

SPEAKER GOIN: The adoption of this section of the report and authorization of the Committee to carry out the policy it sees fit in regard to pensioning employees is moved. Any discussion? All in favor say, "Aye," contrary, "No." This section is adopted.

Report of Committee on Hospitalization Subsidy:

The Committee on Hospitalization Subsidy, of which Doctor John Hunt Shephard is Chairman, has filed a progress report with the House of Delegates, in which it is pointed out:

(1) that a final legal opinion on the legality of hospitalization subsidy had not been secured;

(2) that various members of the State Legislature, when interviewed were opposed to any action at this time that would require any new or shifting of tax burden; and

(3) that on account of increased wages and decreased unemployment during the past year, many doctors are less interested than previously in any change in the ways and means of payment for medical costs. This Special Committee was, therefore, not prepared to submit a comprehensive report at this time.

Your Reference Committee has reviewed this report and wishes to call to the attention of the House of Delegates the fact that the American Medical Association opposes the principle of hospitalization subsidy, and it, therefore, feels that any effort in behalf of State or Federal hospitalization subsidy be not approved. As Chairman, I move the adoption of this section of the report.

DOCTOR HOPE: I second the motion.

SPEAKER GOIN: Your adoption of this is in concordance with your action in supporting the amendment proposed by Doctor Halley in the other Committee report. Is there any discussion? All in favor say, "Aye," contrary, "No." Carried. This section is adopted.

Report of Committee on California Industrial Accident Commission Fee Schedules:

This Committee, of which Doctor Morton R. Gibbons is Chairman, has submitted to your Reference Committee a report to substitute for the one presented to the House

of Delegates. The substituted report reads as follows:

This is a report of the Committee delegated by the President of the California Medical Association to investigate the advisability of seeking an increase in the Industrial Accident Fee Schedule in pursuant to a resolution introduced at the 1941 House of Delegates by the Alameda County Medical Association.

After careful consideration of the various factors involved, and with the advice of the Council of the California Medical Association, your Committee wishes to submit the following report and make the recommendations suggested below:

1. That the Industrial Accident Fee Schedule be increased, as follows:

(a) That hospital, office, and home visits be increased 50 per cent.

(b) That all other fees, either listed on the schedule or unlisted, be increased 25 per cent.

2. Your Committee feels that it is inadvisable to establish separate specialty schedules, such as have been requested by the various specialty groups.

3. Your Committee agrees that there are many abuses and shortcomings in the administration of Industrial Fee Schedules, but believes that these difficulties should be considered separately from the Fee Schedule itself.

4. Your Committee recommends that the above suggestions be placed before the Industrial Accident Commission for action.

Respectfully submitted,

MORTON R. GIBBONS, M. D., *Chairman*

FRANK A. MACDONALD, M. D.

CARL L. HOAG, M. D.

Your Reference Committee approves the report of this Special Committee, and further suggests that in carrying out the recommendations of this Special Committee on the California Industrial Accident Commission Fee Schedules, the Council of the California Medical Association appoint a Committee to place the recommendations of this Special Committee on California Industrial Accident Commission Fee Schedules before the California Industrial Accident Commission. As Chairman, I move the adoption of this report.

DOCTOR GREEN: I second the motion.

SPEAKER GOIN: Any discussion? Doctor Cass of Los Angeles.

Discussion:

DOCTOR CASS: The question of increasing Industrial Accident Fee Schedule has been one that the section of the Standing Committee on Industrial Practice has had in consideration for several years, and a satisfactory working out of this problem has been very difficult because, in the first place, the Industrial Accident Commission is not in the least bit interested in increasing doctors' fees. They are interested in their own job, and it is up to the doctors to get this increase in fees in a different way than by just asking the Commission. My purpose in coming up here now is to state that I believe in a plan by which this report could be amended so that a Fee Schedule be prepared by this Committee, approved by the Council of California Medical Association, and adopted by the House of Delegates as a fair Industrial Accident Fee Schedule and be submitted to the Industrial Accident Commission, and also be submitted to our own members in such a way that it would be more or less obligatory on our members to accept this Fee Schedule. Now, this carries with it a lot of side work which is difficult to comprehend in one motion; such as, the penalties that we will accrue if these Fee Schedules are not adhered to. That is a very difficult problem, because we all know that irregular practitioners will do the work for less money than we if we put our Fee Schedule too high.

I would like to suggest, as an amendment to the report, that a substantial, fairly complete Fee Schedule be prepared by this Committee rather than just an arbitrary percentage of increase in fees.

SPEAKER GOIN: Do I hear a second to the amendment?

DOCTOR KNEESHAW: I second the amendment.

SPEAKER GOIN: Is there discussion? Question is on the adoption of the amendment proposed by Doctor Cass. Any discussion? All in favor say, "Aye," contrary, "No." The "Aye's" seem to have it. The "Aye's" have it. The question is on the adoption of this section of the report as amended. All in favor say, "Aye," contrary, "No." This section is amended.

Report of Committee on Medical Preparedness:

This Special Committee, of which Doctor Harold A. Fletcher is Chairman, has presented an excellent report, which your Reference Committee approves. It is also the feeling of your Reference Committee that the Committee on Medical Preparedness, and particularly its Chairman, Doctor Philip K. Gilman and his successor, Doctor Harold A. Fletcher, have done in a highly commendable fashion, a tiresome and thankless job, which should meet with the commendation of all of the members of this House of Delegates and the California Medical Association. As Chairman, I move the adoption of this section of the report.

DOCTOR PALLETTE: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." It is carried.

Report of the Legal Department:

Your Committee reviewed the report of the Legal Department, which it approves. As Chairman, I move the adoption of this section of the report.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Any discussion? Doctor Alesen.

Discussion:

DOCTOR ALESEN: Mr. Speaker, this is an excellent report. I feel that it may be buried in the archives, without due notice being taken of it unless something is done at this particular time. I want to read one imposing and particularly interesting and instructive paragraph.

The profession has been facing the legislative thinking in terms of legislative action. It has been prepared to defend itself against legislative attack and it has successfully done so. But, while the profession is furnishing a legislative front, and thinking in terms of legislation, an entirely different attack is being planned and executed by a different branch of government; namely, the executive or administrative branch. If the profession wheels about and faces the administrative threat, it may suddenly find itself defeated from the rear, while it has had its guns trained on the front.

Mr. Speaker, I move an amendment to this report:

(1) That the House of Delegates commend the Legal Department for this excellent report;

(2) That the Central Office be instructed to reprint these essential parts and to send a copy of this report to every member of the California Medical Association and every member of the Dental Societies in this State.

SPEAKER GOIN: Seconded by Doctor Bailey. Any discussion? Doctor Ayres of Los Angeles.

DOCTOR AYRES: This is rather a small thing to take issue with and I certainly think that the Legal Department deserves all of the support and approbation that we can give it. But, I just want to call attention to the fact, in passing, that the serious and hidden dangers of Governmental Bureaus and so forth merely mean that changes in conditions require changes in the functions of Government and that one of the ferocious bureaus that

we are all hollering about is the Procurement and Assignment Service, which is a Governmental Bureau, and which, it seems to me, far from working in direct opposition to the practice of medicine, has shown 100 per cent cooperation through the American Medical Association. Another one of these monstrous bureaus with which the Government is threatening to impose socialized medicine upon the medical profession is the Defense Housing Project, which cooperated 100 per cent with the medical profession through California Physicians' Service in the rendering of medical care to people coming under that assignment. Other Bureaus could be cited such as the Farm Security Administration in which again the Government has shown an interest and a desire to cooperate with the medical profession, and I just simply raise my voice to call attention to these facts. Now, if it desired to pass this amendment, and spend the extra money in sending out this rather interesting epistle to all of the members of medical and dental professions, so be it.

SPEAKER GOIN: Any further discussion? The question is on the adoption of the amendment. Are you ready for the question? All in favor say, "Aye," contrary, "No." The Chair is in doubt. Will those voting "Aye" please rise? Be seated, gentlemen. The vote is 46 for the amendment and 42 against. Therefore, it is carried. The question is now on the adoption of the report as amended. Are you ready for the question? All in favor say, "Aye," contrary, "No." It is carried.

Report of Physicians' Benevolence Committee:

Mr. Speaker, may I ask that in view of the fact that this report is printed and in the hands of all of the delegates, and since the hour is late, may I proceed without reading the report of this Committee.

SPEAKER GOIN: I think you may read the Committee's conclusions and recommendations.

DOCTOR WILBUR: Your Reference Committee considered the report of the Physicians' Benevolence Committee in two parts:

(1) The first part of the report deals with the care and disbursement of aid to our needy members; and

(2) The second part deals with the suggested amendment to the by-laws.

(a) Your Committee, after having considered this carefully, approves of the first part of the report, dealing with the care and disbursement of aid to our needy members, and as Chairman, I move adoption of this section of the report.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." Carried.

DOCTOR WILBUR:

(b) Inasmuch as the second part of the report deals with an amendment to the by-laws, and since this amendment is to be considered separately and subsequent to the Committee Report, we request that the vote on the second part of the report be withheld until after the vote on the amendment to the by-law has been taken.

(c) Proposed Amendment to the By-laws No. 1—Concerning Physicians' Benevolence Committee:

May I ask again, Mr. Speaker, if we can delete reading of this proposed amendment which has been published in the Pre-Convention Bulletin, and is also in the hands of each member of the House.

SPEAKER GOIN: Yes, would the House like Mr. Peart again to say briefly what the purpose of this amendment is? It is very involved in its phraseology.

DOCTOR WILBUR: May I say one word in that respect, Mr. Speaker? The Reference Committee has prepared a substitute to this amendment which is very brief. In

view of the presentation of this substitute amendment possibly you would like to hear it, and not the proposed amendment which was published a year ago and again in the Pre-Convention Bulletin.

SPEAKER GOIN: That is wise.

DOCTOR WILBUR: The Reference Committee is of the opinion that the proposed by-law amendment No. 1 is not correct in policy, and will not be workable and satisfactory over a long period of time, for the following reasons:

1. The Reference Committee feels that the allocation of \$1.00 per year per member from the dues of the California Medical Association would, before long, lead to the accumulation of a considerable sum of money;

2. To allocate this fund to the control of a separate committee of the California Medical Association would lead to decentralization of our funds, and might set a precedent for doing so with other committees, thereby removing control of funds of California Medical Association from the Council of the California Medical Association, where it rightfully belongs.

The Reference Committee recommends that the proposed amendment No. 1 to the by-laws be not adopted. I hereby move adoption of this section of the report.

DOCTOR CLINE: I second the motion.

SPEAKER GOIN: The adoption of this section of the report will have the effect of defeating the amendment which is published here. Are you ready for the question? All in favor say, "Aye," contrary, "No." It is carried.

DOCTOR WILBUR: The Reference Committee does, however, offer a substitute amendment to the by-laws reading as follows:

Substitute Amendment to By-laws:

(d) *Resolved*, That Section 23 of Chapter V, of the By-laws of this Association, California Medical Association, be and the same hereby is amended by deleting the words, "Committee on Aid to Needy Members," from the title and the body of said section wherever said words appear, and substituting therefor the words, "Physicians' Benevolence Committee," and by deleting from said section the words, "Special Fund for Aid to Needy Members" wherever the said words appear and substituting therefor the words "Physicians' Benevolence Fund."

The foregoing substituted amendment merely changes the name of the Committee, in accordance with the Committee's request, and I, therefore, hereby move the adoption of said substitute amendment.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." Carried.

DOCTOR WILBUR: The Reference Committee also recommends:

(e) That the House of Delegates instruct the Physicians' Benevolence Committee to submit in each year to the Council of the California Medical Association a budget which is estimated will be sufficient to take care of our needy members for the ensuing year.

It is further recommended that the Council be instructed to be generous and liberal with appropriations for the care of these needy members. I move the adoption of this section of the report.

DOCTOR DOYLE: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." Carried.

Donation to Physicians' Benevolence Fund by Woman's Auxiliary:

DOCTOR WILBUR: In this connection, Mr. Speaker, I should like to state:

(f) That the Woman's Auxiliary of the California Medical Association has presented to the Benevolence

Fund of the California Medical Association, or will present on May 15, a check for \$735 for the use of the Physicians' Benevolence Committee. May I ask, perhaps out of order, that the House of Delegates, by a vote of thanks to the Woman's Auxiliary, express thanks for this gift.

SPEAKER GOIN: We will ask the House to rise in an expression of a vote of thanks. (House rose.)

* * *

Concerning Proposed Amendment Relating to Physicians' Benevolence Fund:

DOCTOR WILBUR: To return now to the final part of the report of the Physicians' Benevolence Committee:

(g) Following consideration by the House of Delegates of the proposed amendment to the By-laws No. 1, the Reference Committee wishes to present for consideration the second portion of the report of the Physicians' Benevolence Committee. It is the recommendation of the Reference Committee that this portion of the report dealing with a proposed amendment to the by-laws, allocating a portion of the dues of members of the California Medical Association for use by the Physicians' Benevolence Committee, be not accepted. I move the adoption of this section of the report.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: All in favor say, "Aye," contrary, "No." This section of the report is adopted.

* * *

DOCTOR WILBUR: *Your Reference Committee on Medical Service Rendered by Hospital Associations* submits the following report:

The statement of policy, adopted by the Council of the California Medical Association on October 26, 1941, expresses very clearly the position of the medical profession, and should be reiterated at this time and officially adopted by the House of Delegates.

The California Medical Association has consistently endorsed the principles of hospital service insurance and, upon request, the Council of the California Medical Association has given its approval to some or all of the activities of local hospitalization associations. The California Medical Association recommends only those hospital contracts which provide straight hospital services. It does not give and it never has given approval to any contracts which provide medical benefits or services as a part of hospital services. It does not object to the provision of limited diagnostic medical services (x-ray and laboratory), along with hospital benefits, provided that these are arranged for on some ethical and legal basis, such as reimbursement or indemnification.

Your Committee feels that the officers and Council of the California Medical Association should use every effort to have all Hospital Associations operating in California carry out the above policy, both in spirit and in letter.

The Reference Committee has reviewed the report of the Committee on Medical Services Rendered by Hospital Associations, and recommends adoption of it. I hereby recommend the adoption of this section of the report.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." This section is adopted. Doctor Wilbur, on the proposed amendment regarding dues of members in military service, don't you think you might go to where you explain the essence of the amendment. They have all had it.

* * *

**Re: Proposed Amendment No. 1 to Constitution.—
State Association Dues of Members in Military
Service. Adopted**

DOCTOR WILBUR: In relationship to proposed amendment No. 1, may I, at the suggestion of the Speaker, read the conclusions of the Committee. The essence of this amendment is that annual dues may be reduced or waived with respect to those members serving in the Armed Forces of the United States. The Committee is unanimous in its approval of this amendment, and I, as Chairman, therefore, move the adoption of this amendment. It has been printed twice on this sheet with minor changes made with the aid of our legal counsel. These changes were made to clarify the meaning of this Constitutional Amendment by the insertion of the words, "dues for any part of any year," so that there will be no misunderstanding as to whether the years be 1940 or 1941. So that the dues of members may be waived for any part of any years that they are in the Armed Forces of the United States. I, therefore, as Chairman of the Committee, recommend the adoption of this Constitutional Amendment as modified.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Is the House content to waive complete reading of this? Doctor Wilbur has given you the essence of it. The long phraseology is merely to make clear what is to be done. Ready for the question? All in favor say, "Aye," contrary, "No." The amendment is adopted.

* * *

**Re: Proposed Amendment No. 2 to Constitution.—
On Manner in Which State Association Funds
May Be Raised. Adopted**

DOCTOR WILBUR: In regard to *Proposed Amendment No. 2*, which has been published in the Pre-Convention Bulletin and again is available for you here. Mr. Speaker, may I delete reading this Constitutional amendment and come to the report.

This proposed amendment states in brief those *Ways in Which Funds May Be Raised by the California Medical Association*, and has, as its principal addition, a clause stating that, "In the event that the House of Delegates levies any special or other assessment other than the annual assessment of dues, it may, in the resolution levying the assessment, fix and determine the time within which such assessment must be paid, the class or classes of members of the Association upon whom it is levied, and the penalty, if any, including forfeiture or suspension of membership in this Association, or the component County Medical Society, or both, to result from non-payment thereof within the time prescribed." Your Reference Committee has considered this amendment, and has unanimously approved of it. I, as Chairman, therefore, move the adoption of this section of the report, rather, Constitutional amendment.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Is the House content to waive the entire reading of the amendment? Are you ready for the question? All in favor say, "Aye," contrary, "No." The amendment is adopted.

* * *

**Re: Proposed Amendment No. 3 to Constitution.—
On Terms of Office of Speaker and Vice-Speaker.
Not Adopted.**

DOCTOR WILBUR: Proposed Amendment No. 3. *A Proposed Amendment for Three-Year Terms for the Speaker and Vice-Speaker of the House of Delegates:*

Resolved, That Section 3 of Article X of the Constitution of the Association, the California Medical Association be, and the same is hereby amended, by deleting from said section the words, "for the term of one year," and inserting, in lieu therefor the following, "for a term of three years," so the said section shall hereafter read as follows:

"Section 3. Term of Office. The House of Delegates shall, at the regular annual session thereof, elect a Speaker of the House of Delegates and a Vice-Speaker of the House of Delegates, each to serve a term of three years, or until their successors are elected and assume office. The Speaker and Vice-Speaker shall be members of the House of Delegates at the time of their election."

The Reference Committee wishes to point out to the House of Delegates certain advantages and disadvantages of this amendment.

The advantages are that, to efficiently fulfill this office, requires experience and ability not equally possessed by all members of the California Medical Association. We recognize that the experience gained in having acted as Speaker of the House for one year or more helps to expedite the efficiency of the handling of the proceedings of the House of Delegates, and knowledge so gained is invaluable in the handling of any controversial measures coming before the House.

The disadvantages are that if, by chance, a member of the House of Delegates should be elected to this important office, and should not possess the skill and ability to deal with the duties of the Speaker of the House of Delegates, it is obvious that a change might be desired before his term of office expires.

If, after the experience of one year, the Speaker of the House of Delegates has been found efficient and capable of handling his duties, he may be reelected annually for as many years as the delegates see fit.

The accepted qualifications of the present occupant of the office of Speaker of the House of Delegates, and his unanimous election to this office year after year, is a persuasive argument for the present method of electing the Speaker of the House of Delegates. However, the Committee submits the proposed amendment without recommendation for determination by the House of Delegates itself.

SPEAKER GOIN: The Chair will entertain a motion on the amendment. Doctor Doughty of San Joaquin.

DOCTOR DOUGHTY: I move that we adopt the report.

SPEAKER GOIN: A motion will have to be made to adopt the amendment.

DOCTOR DOUGHTY: I move the adoption of the amendment.

DOCTOR HALLEY: I second the motion.

SPEAKER GOIN: The amendment is to provide a three-year term for the Speaker and Vice-Speaker. The way to deal with it, is to move that we adopt it, and then to adopt the report. Any discussion? Doctor Ruddock.

Discussion:

DOCTOR RUDDOCK: I would like to speak against this amendment. I wish it were possible to have a man like Doctor Goin as Speaker and have him forever. But, it is possible that some man may be elected whom we don't want, and we may have him for three years. It is the most important office, I believe, that this House of Delegates can offer to any of its members. If we had a bad man up here, he may be able to take a load off these Reference Committees and steer things through this House of Delegates which we would not want at all. I, therefore, speak against this, and I might say that we had a caucus of the delegates of Los Angeles, Orange, Riverside, I think San Bernardino, and we went in caucus unanimously against this amendment.

SPEAKER GOIN: Any further discussion? Are you ready for the question? All in favor say, "Aye," contrary, "No." The amendment is lost.

* * *

Re: Proposed Amendment No. 4 to Constitution.— On Authority of Council to Contract with Hotel Managements. Adopted

DOCTOR WILBUR: In regard to *Proposed Amendment No. 4*, may I suggest that since it has been published

previously that it be not read at this moment.

The Reference Committee recommends the insertion of the word "five" for the number fixing the number of consecutive annual sessions to be held according to this amendment. I move the adoption of this amendment.

DOCTOR SHARPE, Monterey: I second the motion.

SPEAKER GOIN: Is there any discussion? All in favor say, "Aye," contrary, "No." The amendment is carried.

DOCTOR WILBUR: At this point this Committee would like to read a communication from the California Physicians' Service. The Reference Committee has had referred to it the following letter:

(LETTER)

San Francisco, May 5, 1942.

Dr. Philip K. Gilman,
Chairman of the C.M.A. Council.
Dear Doctor Gilman:

At the meeting of the Administrative Members of California Physicians' Service, held at Del Monte on Tuesday, May 5, 1942, the following resolution was unanimously approved:

Resolved, That the Secretary be requested to communicate with the House of Delegates of the California Medical Association, asking that the liaison committees that were appointed last year be continued, and urging that they function more enthusiastically, to the end that the problems and the status of California Physicians' Service may be better known to the membership at large.

Very sincerely,

A. E. LARSEN, M. D., Secretary.

The Reference Committee heartily endorses the content of this letter.

1 1 1

Re: Industrial Accident Code.—Objectionable Practices

DOCTOR WILBUR: *Resolution No. 1. This Resolution, introduced by Samuel Ayres, Jr., Chairman of the Legislative Committee of the Los Angeles County Medical Association, reads as follows: . . . Mr. Speaker, since this resolution was read at the previous meeting, may I read the conclusions of the Committee.*

Your Reference Committee has discussed the content of this resolution, particularly the fact that its content is expressed in general terms, and it is felt that these general terms are advisable in that they permit considerable latitude in the manner in which the Committee on Public Policy and Legislation of the California Medical Association may prepare or approve suitable amendments to the Industrial Accident Code, the same to eliminate objectionable practices and abuses which have occurred in the past in relationship to compensation insurance practice. The Committee unanimously approves this resolution, and I, therefore, move its adoption.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: Any discussion? All in favor of the adoption say, "Aye," contrary, "No." The amendment is adopted.

1 1 1

Re: Un-American Activities

DOCTOR WILBUR: *Resolution No. 2. Un-American Activities.*

This resolution, the purpose of which is self-explanatory, was introduced by Doctor H. R. Madeley of Solano County. May I, Mr. Speaker, read the conclusions of the Committee?

In order to simplify the content but not modify the meaning of this resolution, the Reference Committee wishes to present in its place the following *Substitute Resolution*:

WHEREAS, The Members of the Medical Profession are, and have been since the formation of the Republic, loyal, patriotic citizens; and

WHEREAS, In time of peace and in time of war, the members of our profession have devoted their energies, their material resources and, when occasion has demanded, their lives for the protection of the lives and

property of their fellow citizens, and for the preservation of the American way of life; and

WHEREAS, There may be within the State of California a few members of the Medical Profession duly licensed to practice the healing art who are disloyal to our country; and

WHEREAS, It is the opinion of the members of the House of Delegates here assembled that medical practitioners guilty of such conduct should no longer be allowed to legally practice the healing art in the State of California; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association, in Convention duly assembled, does hereby instruct the members of the Committee on Public Policy and Legislation, and the General Counsel of the Association, to consult with the members of the Board of Examiners and such other bodies as they may deem wise, to the end that enabling legislation be introduced at the next session of the California Legislature which will make the establishment of such disloyal conduct, by the duly constituted authorities, cause for the revocation of the license to practice medicine held by those guilty of such un-American activities.

I move the adoption of this Substitute resolution.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Is there any discussion? Doctor Ferrier of Los Angeles County.

DOCTOR FERRIER: I think that the Society here is taking a hand in something that it isn't called on to undertake, because the Federal Government is well prepared to look after these cases and to take action, and if persons are proved guilty of treason, they are automatically taken care of under the present law.

DOCTOR DOUGHTY: I move that this resolution be tabled.

DOCTOR ALESEN: I second the motion.

SPEAKER GOIN: All in favor say, "Aye," contrary, "No." The Chair is in doubt. Will those voting "Yes" stand? Motion is carried.

Re: Democracy in Organized Medicine

DOCTOR WILBUR: *Resolution No. 3. Democracy in Organized Medicine:*

This resolution, presented by Doctor Russell Fletcher of San Francisco, is self-explanatory, and your Committee unanimously approves of the resolution as of particular merit at such a time when democratic institutions are being threatened from within as well as from without. The resolution reads as follows: . . .

Since this resolution has been read before the House and is here in your hands now, may I ask, Mr. Speaker, that it not be necessary to read this again. I move the adoption of this resolution.

DOCTOR WARD, San Francisco: I second the motion.

SPEAKER GOIN: Is there any discussion? Are you ready for the question? All in favor say, "Aye," contrary, "No." The motion is adopted.

DOCTOR WILBUR: *Resolution No. 4. Resolution Regarding Improvement of Relations Between Physicians and Insurance Companies:*

This resolution, introduced by Doctor L. Henry Garland of San Francisco, has to do with defining, clearly, differences between services rendered by hospitals and by doctors, so that there may be no misunderstanding by patients, hospitals, physicians or insurance companies as to whether or not payments rendered to hospitals are for hospital or for professional medical care. The resolution reads as follows: . . .

And Mr. Speaker, since this resolution has been read already, may I dispense with reading it? Your Reference Committee unanimously approves this resolution and I, therefore, as Chairman, move the adoption of this resolution.

DOCTOR WARD: I second the motion.

SPEAKER GOIN: If any member objects to passing

over these resolutions, without reading them, he has a privilege of saying so. Hearing no objection, I assume there is none. Is there any discussion? Are you ready for the question? All in favor say, "Aye," contrary, "No." This amendment is adopted.

Re: Rebating and Unethical Practices

DOCTOR WILBUR: *Resolution No. 5. A Resolution Regarding Ethical Practices—Regarding Rebating and Unethical Practice of Referring Patients to Commercial Organizations, etc.:*

This resolution, introduced by Doctor Wilbur Bailey of Los Angeles, is as follows in the printed form.

The Reference Committee, after consideration of the resolution, wishes to modify the last paragraph of it, and supplement it so that the substituted resolution reads as follows. If you do not wish to have me read all of the resolution, I should like to read that part which the Committee has modified:

Resolved, That it be declared unethical for the Members of the California Medical Association or its component branches, to refer patients to commercial organizations, laboratories, or other physicians who advertise to the public and others than the medical profession, who employ steerers or cappers, or who offer to pay rebates or commissions or in any other manner, violate the Code of Ethics of the American Medical Association or its component branches; and be it further

Resolved, That any physician violating this resolution be subject to whatever disciplinary action is deemed advisable by the County Society of which he is a member.

In considering this resolution, the Reference Committee has knowledge that the following action was taken at the Council of the California Medical Association at its 302nd meeting held on Tuesday, May 5, 1942:

"That the Council instruct the California Medical Association delegates to the American Medical Association to present to the House of Delegates of the American Medical Association a resolution having for its purpose the outlawing of rebates of all kinds in accordance with long-standing principles of medical ethics."

The Reference Committee approves of the substitute resolution, and commends the Council of the California Medical Association for its action.

I move the adoption of this substitute resolution.

DOCTOR DOYLE: I second the motion.

SPEAKER GOIN: Is there any discussion? Are you ready for the question? All in favor say, "Aye," contrary, "No." This section of the report is adopted.

Re: New Resolution.—Shasta-Trinity County Medical Society

DOCTOR WILBUR: In accordance with the provisions of Section 2 of Article III, and Section 9 of Article V of the Constitution of the California Medical Association, the following new resolution is submitted by your Reference Committee No. 3, unanimous consent being requested, Mr. Speaker, to present the same at this time.

SPEAKER GOIN: Does the House give unanimous consent? Do I hear any objections? You may proceed.

DOCTOR WILBUR: Resolution follows:

WHEREAS, At the present time, physicians of Trinity County are members of the Shasta County Medical Society; and

WHEREAS, Trinity County belongs to the Ninth Councilor District of the California Medical Association, while Shasta County is included in the Eighth Councilor District; now be it

Resolved, That Trinity County be transferred from the Ninth to the Eighth Councilor District, and that said districts be regrouped accordingly, without any changes to the remaining districts, and that a charter be granted to said two counties under the name of the Shasta-Trinity County Medical Society.

Unfortunately from your mimeographed sheets was

deleted this paragraph, the Committee's action regarding this change in district allocation.

The purpose this resolution accomplishes is requested by the members of the County Societies involved, and is acceptable to the Councilors of the Eighth and Ninth District. I move the adoption of this resolution.

SPEAKER GOIN: This amendment of the Constitution lay upon the table of the House for one year, so that no action has been taken at this time.

SECRETARY KRESS: Mr. Speaker, the by-laws provide that once in every ten years the Council and the House of Delegates shall make a reapportionment of the Councilor Districts. The House can therefore authorize the proposed change in district allocation.

SPEAKER GOIN: This does not involve amending the Constitution. Dr. Green moves to adopt this resolution. Is there a second?

DOCTOR KIRKPATRICK: I second the motion.

SPEAKER GOIN: Any discussion? All in favor say, "Aye," contrary, "No." This section of the report is adopted.

* * *

DOCTOR WILBUR: At this point, Mr. Chairman, I should like to thank the other members of the Reference Committee No. 3, and also the young ladies in the office of the Secretary-Editor who have been so helpful to us in preparing this report, and to those members of the House of Delegates who have been kind enough to appear before the Committee and offer help in preparing this report; and I, as Chairman of Reference Committee No. 3, move the adoption of the complete report as amended by the House of Delegates.

DOCTOR MADSEN: I second the motion.

* * *

Re: Reconsideration of Resolution on Un-American Activities

DOCTOR MURRAY: I realize that it is quite late, but I am not satisfied with the action that was taken in refusing that resolution on subversive activities. I think, perhaps, a letter from Doctor Pinkham might explain why that resolution. . . .

SPEAKER GOIN: Just a moment, we will have to have a motion to reconsider. Who will make the motion?

DOCTOR KILGORE: Mr. Speaker, I move to sustain the reconsideration of the resolution.

DOCTOR HOPE: I second the motion.

SPEAKER GOIN: The motion is on the reconsideration of that portion of the report dealing with the resolution on un-American activities. All in favor say, "Aye," contrary, "No." The "Aye's" have it, and it, the resolution, is open for further discussion.

DOCTOR MURRAY: I wish to read this letter which I think is self-explanatory.

(LETTER)

To the California Medical Association:

Attention: Committee on Public Policy and Legislation:

The Board of Medical Examiners, individually and collectively, have been approached on several occasions on the question of whether the business and professional code relating to the practice of medicine provides any means for punishment for a charge of subversive activities, and goes on to mention the names of some doctors.

There is no provision in the present code permitting the Board to take any action, and we submit for your consideration the question on whether the California Medical Association will sponsor any amendment along the line mentioned for introduction at the next legislative session.

* * *

I quote from a second letter, in regard to the subject in which the same issues are mentioned, and the names of the doctors who have been accused are mentioned. It ends saying,

"We are now engaged in a search of our files to learn the names and addresses of foreign-born aliens, particularly from enemy nations."

We trust that these amendments may be prepared for consideration at the coming legislative session. Thank you very much, Mr. Speaker.

SPEAKER GOIN: Status of this resolution is now the same as it was before you tabled it. There is a motion now pending by the Chairman of the Committee to adopt it. The motion is on the adoption of that section of the report that contains the resolution on un-American activities. Any discussion? Doctor Ayres has the floor.

Discussion:

DOCTOR AYRES: According to the letter from Doctor Pinkham, the suggestion is made that disciplinary action should be taken against a member who is charged with un-American activities. I don't see how it is possible to take any kind of an action if a person is merely charged with some subversive activity. If the individual has been proven to be guilty of it, it would be automatically taken care of by Federal statutes as was previously pointed out. It would hardly seem fair to deprive a person of his right to practice medicine merely because he is accused.

SPEAKER GOIN: Any further discussion? Doctor Kirkpatrick, Shasta Dam.

DOCTOR KIRKPATRICK: Until this item of subversive activities is clarified, I move that this amendment be tabled.

DOCTOR DOUGHTY: I second the motion.

SPEAKER GOIN: The motion is now on again tabling the resolution. All in favor say, "Aye," contrary, "No." Those voting "Aye" please rise. The "Aye's" have it. The question now is on the adoption of the report as a whole as amended. Are you ready for the question? Doctor Madsen.

* * *

DOCTOR MADSEN: You slid over a communication concerning California Physicians' Service, which was directed to P. K. Gilman, Chairman of the Council of the California Medical Association. I think the report of the letter is excellent, but I feel that the liaison mentioned in the letter should be between our members and the California Physicians' Service. It seems to me that it is high time that the California Physicians' Service per se be placed in the position where it need not come to Del Monte and defend itself. We all brought California Physicians' Service into existence, and if it is possible in any way to imply that the function of this Liaison Committee should be to carry information to the members of the House of Delegates or the members at large, I should like to see, or ask, that that be recognized. The communication was merely read to the Chairman of the Committee. No action was taken, whatsoever.

SPEAKER GOIN: Well, I don't know of any way that you could stop the members of the California Physicians' Service and the Trustees who are Delegates to this Association to bring up a resolution if they wanted to, Doctor Madsen. They are all privileged to bring in a resolution as they see fit. The question now recurs of the adoption of the report as a whole as amended. Are you ready for the question? All in favor say, "Aye," contrary, "No." Adopted.

I would like to add my thanks to those of Doctor Wilbur to include Doctor Wilbur for the heavy work that this Committee has gone through. (Applause.) They sat for nearly all of two days. At this time, the Speaker would like to confess his own error, assisted by the Executive-Secretary, when, inadvertently having mislaid our list of committees, we announced Doc-

tor Huffman as a member of Doctor O'Neill's Committee No. 1, in place of Doctor McPherson of Santa Cruz County, who really was the member and who served faithfully, and also Doctor Key, and I thank both of them and apologize to Doctor McPherson for not having named him yesterday.

Next order of business is unfinished business. I'll call upon the Chairman of the Council, Doctor Gilman, to discuss the dues for next year and the budget.

Re: State Association Dues for 1943

DOCTOR GILMAN: Mr. Speaker, for the year 1943, the Council recommends the *annual assessment to be \$20 per member*. I move the adoption of this recommendation.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Any discussion? We are about to fix the dues for next year. Are you ready for the question? All in favor say, "Aye," contrary, "No." Carried.

Re: Budget for Year 1943

DOCTOR GILMAN: Mr. Speaker, the Chairman of the Council wishes to announce the *Budget for the Year 1943* at the estimated income and dues to be set at \$80,000 instead of the previous estimation of \$96,000, owing to the increasing number of members entering into the military service. This is for your information and no particular action is necessary. This income as stated a moment ago if from membership dues, this \$80,000. Estimated income from advertising sales \$25,000. General subscriptions \$600. Reprint sales \$500. Annual session \$6,000. Miscellaneous, including earned interest, \$1,500. A total of \$115,600 as against the previous \$129,600. There is a total for expenditures of \$95,828, leaving an estimated balance of \$17,772. I move the adoption of the budget, gentlemen.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: Any discussion? Are you ready for the question? All in favor of the adoption of the budget say, "Aye," contrary, "No." Carried.

Introduction of President William R. Molony

We now come to the more enjoyable part of the agenda and I now have the pleasure and the honor of introducing to you, your new President, Doctor William R. Molony of Los Angeles.

DOCTOR MOLONY: Mr. Speaker, President Rogers, and Members of the House of Delegates: A year ago at Del Monte you honored me by electing me President-elect of the California Medical Association. Needless to say, I was extremely appreciative, and tonight, after a year's service to the California Medical Association as your President-elect, I became your President. On this occasion you will permit me to delve into some past history of a personal nature. My experience with the affairs of the California Medical Association goes back to about 1910. A few years later, I was appointed and served as Chairman of the Reference Committee of the House of Delegates in Coronado. At that time, there was only one Reference Committee. That annual session was held during the administration of Doctor George H. Kress, who was State Association President at that time. Since then, I have taken an active and continued interest in the California Medical Association. For twenty-seven years, beginning with 1913, I was honored and very happy in the privilege of serving the State of California and my colleagues in medicine as a member of the Board of Medical Examiners, for which board I had the pleasure of serving as President some years. For an entire decade, also, it has been my great pleasure and honor to serve as a delegate to the American Medical Association from California. About ten years

ago, my colleagues in Los Angeles, my native city honored me by electing me President of the Los Angeles County Medical Association. All these honors and privileges have been dwarfed by the great honor that has come to me tonight, when I became President of the California Medical Association. The only regret arises from the fact that my wife, who has been with me through all my trials and labors for forty-five years, is unable tonight, by reason of ill health, to share with me in this honor tonight. However, I feel that, to be the President of this organization and to look back upon the illustrious line of great men who year after year, have served as your Presidents, one should be proud to follow in their footsteps. May I say to you that I shall do my very best, not in an effort to excel them, because that can't be done, but to emulate their examples and try to promote all the traditions and ideals that will make for betterment of medical conditions in California. I thank you. (Applause.)

Introduction of President-Elect Karl L. Schaupp

SPEAKER GOIN: I shall now ask Doctor Philip Gilman and Doctor Lowell Chandler to escort Doctor Karl L. Schaupp to the rostrum. Delegates, your President-elect, Doctor Karl L. Schaupp of San Francisco. (Applause.)

DOCTOR SCHAUPP: Thank you all for this honor which you have placed upon me. I shall try in the following year as President-elect to gather up the threads that I have lost touch with, in the last two years. I shall try in every way possible to carry out thoroughly and fearlessly the wishes of this supreme body of the California Medical Association, the House of Delegates. Thank you. (Applause.)

Remarks of Speaker Lowell S. Goin and Vice-Speaker E. Vincent Askey

SPEAKER GOIN: The Speaker is now directed to present the Speaker, but since it turns out to be "that man again," I will only say that I thank you very much for the expression of confidence, and will continue to try to do the very best that I can, I am pleased to present to you, now, your Vice-Speaker, Doctor Askey. (Applause.)

DOCTOR ASKEY: Members of the House of Delegates and Friends: I don't think that I need to say anything, except that I appreciate the honor which you conferred on me last year and which you have given me again. I thank you very much. (Applause.)

Remarks of Retiring President Henry S. Rogers

SPEAKER GOIN: The Chair now recognizes a past President of the Association, Doctor Harry Wilson.

DOCTOR WILSON: Mr. Speaker and Members of the House: I seem to have the bad duty of helping usher a man out instead of the joyous one of welcoming a man in. The Reference Committee's Report tonight dealing with the President's activities gave you a very slight intimation of the arduous duties that have fallen on Doctor Rogers' shoulders. I don't think any of you can really appreciate what he has given of himself to the Association. Following past custom, and presenting to Doctor Rogers this certificate, which is the acknowledgement of his services to you and the honor which he has received from you, I know it is your hope with me that, as he glances at it from time to time, he will forget the small disappointments that happened to him through the year, and will, on the contrary, remember the many pleasures he had during his years of service. So, I can only welcome Henry who has been so de-

serving into the Ancient Order of Past Presidents. (Applause.)

DOCTOR ROGERS: President Molony, President-Elect Schaupp, Mr. Speaker, and Members of the House: Now that I am leaving you, I would just like to have a little heart-to-heart talk. There is something about this House of Delegates that, when you are elected a President-Elect, no matter how calm you seem to be up to that moment then when you come up here it is impossible to find speech to adequately express your feelings. Also that is true—or at least it was in my case—when one is presented to you as your President. Now, that I am leaving you, to become a Past President, I really want to call to your attention to one impression in this State, that I believe detracts from the effectiveness when the Officials of the Society visit your county societies. It also lessens the effect and value of the editorials on subjects published. I refer to the widespread statements that the officers of the Association and the Council are medical politicians. Now, I am not saying anything about myself, but I have served on this Council for better than eighteen years, and in that time I have never worked with a finer or more broad-minded or scholarly group of men than those you have elected to this Council. They serve you self-sacrificingly. Let us pause and analyze the make-up of your present Council. At the present time, you have five general practitioners; four ear, nose and throat specialists; three surgeons; two internists; two pediatricians; one radiologist; one industrial surgeon; two obstetricians. Seven of these Councilors are teachers in the four medical schools we have in California. All of your Councilors are practitioners who live and work among you, and all are highly respected by their confreres. They are here as your officers because you select them, knowing they are good men and men who will work without stint for the progress of medicine. I would like to ask you, who are here tonight, as members of the House of Delegates, to go back to your County Societies and explain to your fellows, that while your Councilors must be keenly alert to political values and trends, such work in your behalf does not make them politicians, in the cheap sense of that term. They are working for you and for medicine, and they are giving a lot of themselves and a lot of their own money while they are promoting the best interests of medicine of which your own are a part. I give you thanks for being President. I did the best I could and that is all any one man can do. I am now returning to the practice of medicine in a little country town and as the years roll by I hope to devote a little more of my time to reading the literature, watching the new drugs, as they come along, and the new treatments. I shall continue to help the officers of the society in any way that I can, to promote the practice of medicine, which profession is, in my estimation, the finest line of life work any man can take up. I thank you all for the opportunity you have given me to serve you. And I want to thank all of the officers of the Association, the Committees, and particularly those who helped with the entertainment last night. As I am leaving you, gentlemen, I again thank you. (Applause.)

SPEAKER GOIN: I don't know whether or not I ought to let you in on this, but the fact is that, in spite of those two obstetricians on the Council that Doctor Rogers mentioned, the Council sometimes has pretty difficult labor for considerable periods of time. The Chair now recognizes Doctor Sieber of Santa Rosa.

1 1 1

Presentation of Gift to Past President Rogers:

DOCTOR SIEBER: You who come from Los Angeles County and around the Bay Region must get used to

having Presidents picked from among our members, but we from Sonoma County see it as a very rare event. We have been very happy during this past year, and have been very proud to have Doctor Rogers of Petaluma as the State President. In spite of the fact that he has been very busy with the State Association work, he has been a most faithful member of our County Society. In fact, we have had great difficulty in doing anything behind his back. Recently, however, we did do a little underhanded business, and at this time I am very happy on behalf of the Sonoma County Medical Society in presenting Doctor Rogers with this little token of appreciation from the Sonoma County Medical Society. (Applause.) (Presents a handsome case of smoking pipes.)

DOCTOR ROGERS: Doctor Sieber, I'm almost speechless. You know, when I was elected as your President-Elect, I went home and Doctor Peoples, my neighbor, dropped in and said, "Henry, are you going to the medical meeting tonight?"

I said, "My God, I'm tired. I just got in from a trip some place today. I don't really think I ought to go, but I think I will go with you."

And when I got up there, I found these boys had decorated the meeting room with flowers and "what have you." It made me very, very happy. This present gift from these boys with whom I have lived and practiced medicine means a whole, whole lot to me. Thanks to the members of the Sonoma Medical Society.

1 1 1

Committee to Edit Minutes

SPEAKER GOIN: It is customary at this time to entertain a motion to appoint the President, the Association Secretary and the Speaker as a Committee to edit the electrically-transcribed minutes.

DOCTOR RUDDOCK: I so move.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: All in favor say, "Aye," contrary, "No." So ordered.

Vote of Thanks

Before we adjourn, I want to thank the Chairmen and members of the Reference Committees. Those of you who have been on those committees know how much work is involved, how much of your time it takes, and how much it spoils your other enjoyments of the meeting. Someone has to do these chores for the Association, and I am grateful, and I am sure that you are all grateful to all of these men who gave us their time for these other important tasks.

Adjournment

The Chair will now entertain a motion to adjourn.

DOCTOR MADSEN: I second the motion.

SPEAKER GOIN: The House is adjourned.

House adjourned at 12 midnight, on Wednesday, May 6, 1942.

LOWELL S. GOIN, *Speaker*

GEORGE H. KRESS, *Secretary*

Attest: HENRY S. ROGERS, *President, 1941-1942*

WILLIAM R. MOLONY, *President, 1942-1943*

Life is short, the Art long, opportunity fleeting, experience treacherous, and judgment difficult.—*Hippocrates.*

As to diseases, make a habit of two things—to help, or at least to do no harm.—*Hippocrates.*

If disease and treatment start together, the disease will not win the race.—*Hippocrates.*

More mistakes are made by not looking than by not knowing.—*Jenner.*

OFFICIAL BUSINESS

Alameda County Medical Association Resolutions
Concerning Professional Membership in
California Physicians' Service

The minutes of the House of Delegates of the California Medical Association give several references to a resolution adopted by the Council of the Alameda County Medical Association having to do with resignations of professional members of California Medical Association.*

The matter was also referred to in the C. M. A. Council, as noted in the June issue of CALIFORNIA AND WESTERN MEDICINE. (On page 357, Item 8; and on page 358, Item 4.)

Under date of June 3rd, the following were received from Doctor Gertrude Moore, Secretary of the Alameda County Medical Association:

(COPY)

ALAMEDA COUNTY MEDICAL ASSOCIATION
Office of the Secretary-Treasurer
353 30th Street
Oakland, California

June 3, 1942.

Captain Philip K. Gilman,
Chairman, Council of California
Medical Association,
San Francisco, California.

Dear Captain Gilman:

Enclosed please find resolutions passed by the Council of the Alameda County Medical Association at a recent meeting.

Sincerely,

(Signed) GERTRUDE MOORE, M.D., *Secretary*.

Encl.

(COPY)

WHEREAS:

The Council of the Alameda County Medical Association on February 13, 1942, passed a resolution disapproving California Physicians' Service as now constituted and operated and advised the members of the Alameda County Medical Association who were professional members of California Physicians' Service to resign from California Physicians' Service; and

WHEREAS:

The Council of the California Medical Association on May 3, 1942, asked, in the interest of organized medicine that this resolution be rescinded;

THEREFORE, BE IT RESOLVED:

That the Council of the Alameda County Medical Association rescind this resolution of February 13, 1942, relative to California Physicians' Service, effective June 3, 1942; and

BE IT FURTHER RESOLVED:

That this action is taken solely at the request of the Council of the California Medical Association in order to prevent open dissension in the medical profession and does not indicate a change in the opinion of the members of the council of the Alameda County Medical Association relative to the California Physicians' Service.

The "Bulletin of the Alameda County Medical Association," in a subsequent issue, in addition to the resolution printed above, gave additional comment over the

* See Report of Reference Committee No. 2 on page 80.

name of Safford A. Jelte, President of the Alameda County Association, as follows:

(COPY)

PRESIDENT'S MESSAGE

"Your Council has unanimously passed the following resolution:

(Resolution as per above)

"In taking the above action your Council has made an effort to preserve harmony between the official medical bodies concerned; it has, at the same time, reiterated its stand with regard to the present constitution and operation of California Physicians' Service. Its opinion is in no sense binding upon any of the members of this Association, who are perfectly free, as they always have been, to serve California Physicians' Service as professional members, or not, as they see fit. In the long run, a medical payment plan will prosper or fail on its own merits. If it is soundly constituted and operated it will succeed; if not, its ultimate demise may be delayed, but not prevented, by the artificial support of medical bodies organized primarily for scientific advancement.

"Your Council hopes that with the passage of the above resolution the controversy over this matter will be ended."

SAFFORD A. JELTE, *President*.CALIFORNIA COMMITTEE ON
PARTICIPATION OF THE
MEDICAL PROFESSION
IN THE WAR EFFORT**Letter Received from the Federal War
Manpower Commission

Editorial comment on the letter which follows and which was received from Major (now Colonel) Sam F. Seeley appears in this issue.*

Because of its importance, Colonel Seeley's communication is also given place in this column, which hereafter, in general conformity with action taken in Atlantic City, at the A.M.A. session, will hereafter appear under the caption: "California Committee on Participation of the Medical Profession in the War Effort."

(Copy of Telegram Sent to Major Seeley)

WESTERN UNION

June 19, 1942.

Major Sam F. Seeley,
601 Pennsylvania Avenue, N.W.,
Washington, D. C.

To emphasize Mr. McNutt's Atlantic City remarks, we need following information. One, total number of California physicians now in active service in Army. Two, total number of California physicians still needed to meet California's quota at present date. Three, total number

† Harold A. Fletcher, M.D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M.D., 1930 Wilshire Boulevard, Los Angeles.

Henry S. Rogers, M.D., room 1938, 450 Sutter, San Francisco, is a member of the American Medical Association Committee on Medical Preparedness, and is chairman of the Ninth Corps Area Procurement and Assignment Service.

Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86. See also in this issue on following page.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (FEderal 1953).

** Committee on Medical Preparedness department in C. & W. M. will hereafter appear under this caption.

* For editorial comment, see page 1.

of additional California physicians needed for Army by December 31, 1942. Four, average number of California physicians who should enroll each month to permit California to fulfill its quota by December 31, 1942. Kindly send above or related figures.

CALIFORNIA AND WESTERN MEDICINE,
By: GEORGE H. KRESS, Editor,
450 Sutter, San Francisco.

1 1 1

(COPY*)

Office for Emergency Management
WAR MANPOWER COMMISSION
Washington, D. C.

Chairman, Paul V. McNutt
Federal Security Administrator
Procurement and Assignment Service for Physicians,
Dentists and Veterinarians

June 20, 1942.

Dr. George H. Kress, Editor,
CALIFORNIA AND WESTERN MEDICINE,
San Francisco, California.

Dear Dr. Kress:

In response to your telegram of June 19, the following round figures should be used as a basis for your calling to the attention of the medical profession of California the necessity of their early participation in the war effort. California's quota, in addition to interns and residents, is 2600, to be filled by December 31, 1942. Figures in this office indicate that less than 1000 are now in military service and your quota for the balance of the year is to be not less than 1800.

Dr. Harold A. Fletcher, 490 Post Street, San Francisco, and Dr. Edward C. Pallette, 1930 Wilshire Boulevard, Los Angeles, are responsible as our State Chairmen for Physicians in California, to determine the availability of physicians in that State. I would emphasize that the majority of physicians of military age, i.e., those under 45, must anticipate military service sooner or later except in the proven instances where they cannot be spared from civil life.

In the majority of the instances the deferment of a man under 45 can only be considered temporary and wherever necessary a replacement should be obtained from among those over 45, the women physicians, or those under 45 who have been rejected for military service. It is the opinion of this office that more than one-half of California's quota should be filled within the next sixty days and that a minimum of 1800 must enter the military service without fail. Since the question of dependency has practically been eliminated under Selective Service opinions, the remaining cause for deferment is occupational. In those cases where this office considers a man to be available, we feel justified in challenging deferment on an occupational basis. We do not want to have to resort to such a challenge. We look to the patriotism and enthusiasm of the medical personnel in California to meet this demand on a voluntary basis and have set July 1, 1942 as the date to which we look forward when an appraisal of the situation will be carefully considered by the Directing Board in determining its future policies.

Sincerely yours,

(Signed) SAM F. SEELEY, M. D.,

Executive Officer.

Procurement and Assignment Service.

(COPY)

Office for Emergency Management
WAR MANPOWER COMMISSION
Washington, D. C.

Chairman, Paul V. McNutt
Federal Security Administrator
Procurement and Assignment Service for Physicians,
Dentists and Veterinarians

June 25, 1942.

George H. Kress, M. D., Editor,
CALIFORNIA AND WESTERN MEDICINE,
San Francisco, California.

Dear Dr. Kress:

In response to your letter of the 20th, the following comments are offered:

Your figures are correct except for.

Item (4) M. D.'s under age of 45—72,000.

Items (6), (8) and (9) [re: number of California licentiates, etc.], are not known to be correct as far as I can determine. This can be compiled, however, from the list of physicians in military service as of April 30, which has been transmitted to the office of Dr. Fletcher.

My records show that 833 were on active duty from California as of May 1.

Sincerely yours,

(Signed) SAM F. SEELEY, M. D.

California Procurement and Assignment Service

Direct recruiting of medical officers for the Army of the United States is now a reality. Recruiting boards have been established in San Francisco and Los Angeles, and applicants may secure full details, final type physical examinations and Procurement and Assignment clearance in a minimum time. The goal of the recruiting service is to issue commissions to applicants within 48 hours of the time of application; Procurement and Assignment Service is ready to do its share in accomplishing this.

Inauguration of this service means an end to the long waiting periods that many physicians underwent under former procedures. No longer will you have to wait several months to learn whether or not you are acceptable for an Army commission, meanwhile not knowing whether to close your office, turn patients over to other physicians, etc.

The need for Army doctors is greater today than at any time in the past. The Army expansion program has been so accelerated that there is a crying demand for more doctors to enter the service and prepare themselves for active medical work with new troops. Despite rumors of Army doctors doing everything except the practice of medicine, Army doctors are still doctors, albeit in training for a specific type of medical work required by modern streamlined armies. It is important to remember that at least three months of Army training are needed before a physician is able to render proper service as a military physician.

At the A.M.A. meeting at Atlantic City the need for Army doctors was placed squarely before the profession on the basis of a voluntary program which the profession has first chance at carrying out. If the voluntary process fails, pressure will be brought to bear from one of the numerous Government agencies which have been given supreme authority by the Congress. The profession will do well to heed the warning and the need.

California's quota of new Army medical officers for the balance of 1942 is about 1500. This means that an average of 250 doctors a month must be recruited in this

* Major Sam F. Seeley's letter, as received from him, is here printed. It also appears in this issue for editorial comment, with additional paragraphing for convenience in reference.

state for each of the next six months, under penalty of not meeting our quota and thereby laying ourselves open to compulsion by other interests.

A recapitulation of the commissioning process used by the two recruiting offices in California is in order at this time:

1. Physicians under 37 years of age may be commissioned as first lieutenants; those between 37 and 45, as captains.

2. Physicians between 45 and 55 years of age may apply for commissions, their applications to be acted upon by the Surgeon General and commissions granted in ranks commensurate with their professional attainments and openings existing in the Medical Corps.

3. Physicians under 45 may apply for commissions of Major or higher if they are certified by one of the American Boards or if they have other special attainments; these applications must be cleared by the Surgeon General and will be favorably acted upon *only if vacancies exist* where such men may be placed. Physicians in this category should not, however, fail to accept a commission at the rank of Captain if a higher rank is not available. The number of physicians who will obtain initial rank of Major or Lieutenant Colonel is strictly limited. There are already enough medical officers in the Army to qualify for promotion, and newly commissioned physicians will also have the opportunity for promotion available to them.

4. Physicians with prior service in the Army should apply at the same recruiting boards, which will forward their applications to the Surgeon General for action.

For full details, consult the U. S. Army Medical Recruiting Board at 450 Sutter Street, San Francisco, or 1930 Wilshire Boulevard, Los Angeles. Major South in San Francisco and Major Darnell in Los Angeles will be glad to offer you every assistance.

Army needs indicate that within another 12 months every able-bodied physician under 45 years of age will be in uniform. If you come within this group or within the other groups mentioned above, you will promote your own interests by applying now.

Medical Officer Recruiting Board for Southern California

The following item is taken from "The Bulletin of the Los Angeles County Medical Association," issue of June 18, 1942:

The Southern California Medical Officer Recruiting Board has opened permanent quarters at Room 204, Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles. This office is in charge of Major C. A. Darnell.

It is suggested that all doctors desirous of being commissioned in the Army or those who have already applied for commissions a month or six weeks ago and have not heard from their applications, contact Major Darnell at once.

Adjoining these offices are the offices of the Procurement and Assignment Service of Southern California and of Los Angeles County.

The Los Angeles County Committee on Procurement and Assignment Service is composed of the following:

C. G. Toland, M. D., Chairman
Maurice Kahn, M. D.
William H. Kiger, M. D.
Wayland Morrison, M. D.
Fred B. Clarke, M. D., Long Beach
John Dunlop, M. D., Pasadena
William M. Gibbs, M. D., Glendale
John P. Nuttall, M. D., Santa Monica
F. C. Swearingen, M. D., Pomona

Doctor E. M. Pallette has been appointed Vice State Chairman with supervision of the fourteen southern counties.

California Procurement and Assignment Service County Committees for Physicians

COUNTY	CHAIRMAN	MEMBERS
Alameda	Albert M. Meads 251 Moss Ave., Oakland	Warren B. Allen, Oakland Claire Raser, Oakland
Butte-Glenn	D. H. Moulton 341 Broadway, Chico	J. H. Hepplewhite, Chico Eli A. Kusel, Oroville T. H. Brown, Orland C. E. Plumb, Chico
Contra Costa	L. Abbott Hedges 314 10th St., Richmond	J. Robert Harman, Richmond Selby Marks, Pittsburg
Fresno-Madera	C. D. Collins 2607 Fresno St., Fresno	Frank R. Ruff, Fresno George H. Sciaroni, Fresno G. W. Walker, Fresno R. R. Dearborn, Madera
Humboldt	Joseph S. Woolford 350 E St., Eureka	Benjamin M. Marshall, Eureka John A. Lane, Eureka
Imperial	John L. Parker 120 S. 6th St., Brawley	L. C. House, El Centro C. S. Brooks, El Centro
Inyo-Mono	Harvey W. Crook 106 S. Main, Bishop	Lloyd S. Bambauer, Bishop Selda E. Anthony, Independence
Kern	William H. Moore Haberfelde Bldg., Bakersfield	Lucille B. May, Bakersfield Lloyd Fox, Bakersfield Louis A. Packard, Bakersfield Seymour Strongin, Bakersfield
Kings	Lionel W. Sorenson Corcoran	C. G. Newbecker, Hanford Arthur Zeisner, Hanford
Lassen	George S. Martin Susanville	H. G. Levin, Westwood
Los Angeles	C. G. Toland 1925 Wilshire Blvd., Los Angeles	Wayland A. Morrison, Los Angeles Maurice Kahn, Los Angeles ADVISORY BOARD Fred B. Clarke, Long Beach John P. Nuttall, Santa Monica John Dunlop, Pasadena F. C. Swearingen, Pomona William M. Gibbs, Glendale
Marin	Homer E. Marston 1010 B St., San Rafael	George H. Wilcutt, San Rafael M. E. Hazeltine, San Rafael
Medocino-Lake	Raymond A. Babcock Willits	Paul J. Bowman, Fort Bragg Charles A. Craig, Lakeport Royal Scudder, Fort Bragg Lew K. Van Allen, Ukiah
Merced	Fred O. Lien 557 17th St., Merced	A. S. Parker, Merced B. E. McDowell, Merced
Modoc	Philip W. McKenney Alturas	
Monterey	William H. Bingham 308 Main St., Salinas	Rudolph A. Kocher, Carmel George A. Starbird, King City
Napa	Dwight H. Murray 1110 1st St., Napa	G. K. Abbott, St. Helena M. M. Booth, St. Helena
Orange	H. G. Huffman 215 S. Main St., Santa Ana	C. Glenn Curtis, Brea D. A. Harwood, Santa Ana Milo K. Tedstrom, Santa Ana John A. Wood, Anaheim L. F. Whittaker, Huntington Beach

COUNTY	CHAIRMAN	MEMBERS	COUNTY	CHAIRMAN	MEMBERS
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<i>Plumas</i>	W. C. Batson Greenville	W. B. McKnight, Portola B. S. Holm, Quincy	<i>Solano</i>	Ream S. Leachman 727 Sonoma St., Vallejo	John W. Green, Vallejo F. Burton Jones, Vallejo
<i>Riverside</i>	William W. Roblee 3616 Main St., Riverside	Bon O. Adams, Riverside Ralph Smith, Riverside	<i>Sonoma</i>	R. L. Ziebler 834 4th St., Santa Rosa	E. D. Barnett, Santa Rosa Cuthbert M. Fleissner, Santa Rosa S. Z. Peoples, Petaluma Chester Marsh, Sebastopol Frank E. Sohler, Healdsburg Carroll B. Andrews, Sonoma
<i>Sacramento</i>	William J. Van Den Berg 1127 11th St., Sacramento	Orrin S. Cook, Sacramento John L. Fanning, Sacramento Nathan G. Hale, Sacramento Elbert T. Rulison, Sacramento	<i>Stanislaus</i>	Fred R. DeLappe 1901 Downey Ave., Modesto	John A. Cooper, Modesto Hoyt R. Gant, Modesto
<i>San Benito</i>	Roswell L. Hull 446 San Benito St., Hollister	Lloyd E. Smith, Hollister John J. Haruff, Hollister	<i>Tehama</i>	Frank L. Doane 737 Washington, Red Bluff	Homer H. Beck, Corning Arthur H. Meuser, Corning
<i>San Bernardino</i>	Emmett L. Tisinger 575 5th St., San Bernardino	Carlos G. Hilliard, Redlands E. H. Risley, Loma Linda P. M. Lawler, Victorville Francis Crowley, Patton E. L. Weber, Upland	<i>Tulare</i>	A. W. Preston 222 West Willow, Visalia	James C. McClure, Lindsay R. W. Rosson, Tulare C. S. Ambrose, Visalia
<i>San Diego</i>	Bryant Simpson Medico-Dental Bldg., San Diego	L. H. Redelings, San Diego W. W. Crawford, San Diego F. J. Ratty, San Diego R. O. Logsdon, San Diego W. O. Weiskotten (Ex Officio) San Diego	<i>Tuolumne</i>	Homer D. Rose Wenzel Bldg., Sonora	H. W. Schwing, Sonora
<i>San Francisco</i>	John M. Moore, Vice-Chairman 2180 Washington St.	Harold A. Fletcher, Chairman L. R. Chandler, San Francisco Alexander F. Fraser, San Francisco Albert E. Larsen, San Francisco	<i>Ventura</i>	Grundy C. Coffey 23 S. California St., Ventura	Fred A. Shore, Ventura Jabez A. Mahan, Oxnard William Felberbaum, Santa Paula Harold B. Osborn, Fillmore Franklin H. Garrett, Camarillo
<i>San Joaquin</i>	Hudson Smythe Medico-Dental Bldg., Stockton	H. S. Chapman, Stockton Dewey Powell, Stockton R. L. Owens, Lodi J. Frank Doughty, Tracy	<i>Yolo</i>	William J. Blevins Porter Bldg., Woodland	John Homer Woolsey, Woodland Leo A. Cronan, Davis
<i>San Luis Obispo</i>	Ira B. Bartle 722 Marsh St., San Luis Obispo	Harold L. Graham, Arroyo Grande John R. Ransom, San Luis Obispo Frederick F. Ragsdale, Paso Robles	<i>Yuba-Sutter-Colusa</i>	Irving D. Johnson 309 C St., Marysville	Neal M. Loomis, Yuba City Grantville S. Delamere, Marysville Charles E. Kimmel, Marysville
<i>San Mateo</i>	Ernest W. Cleary 146 Chapin Lane, Burlingame	Edwin Bartlett, So. San Francisco William Knorp, San Mateo Carl Benninghoven, San Mateo Robert Monteith, Redwood City Thomas Farthing, San Mateo			
<i>Santa Barbara</i>	Hugh F. Freldehl 1515 State St., Santa Barbara	Albert M. Beekler, Santa Maria Lawrence F. Eder, Santa Barbara Harry E. Henderson, Santa Barbara Harry L. Schurmeier, Santa Barbara Irving Willis, Santa Barbara Alfred B. Wilcox, Santa Barbara			
<i>Santa Clara</i>	A. A. Shufelt 241 E. Santa Clara St., San Jose	Leon P. Fox, San Jose J. Irving Beattie, San Jose D. R. Threlfall, San Jose Robert Powers, Palo Alto J. A. Cary, Morgan Hill Burt L. Davis, Jr., Palo Alto J. C. Cuneo, San Jose George A. Gray, San Jose James P. Lovely, San Jose Max E. Pickworth, San Jose William H. Geisler, San Jose			
<i>Santa Cruz</i>	Alfred L. Phillips 84 Walnut Ave., Santa Cruz	F. E. Blaisdell, Watsonville D. S. Woodard, Watsonville N. R. Sullivan, Santa Cruz Frederick R. Shenk, Santa Cruz			
<i>Shasta</i>	John E. Kirkpatrick Shasta Dam	Clarence C. Gerrard, Redding Benjamin F. Saylor, Redding Julius M. Kehoe (Ex Officio), Redding			

Procurement of Physicians for the Armed Forces

The first editorial in the *Journal of the American Medical Association*, on page 712 of the issue of June 27th, was a discussion having the above caption. The following excerpt is taken therefrom:

"Elsewhere in this issue appears a statement by Mr. Paul V. McNutt, chairman of the War Manpower Commission, under which the Procurement and Assignment Service for Physicians, Dentists and Veterinarians functions, relative to the urgent need for physicians for the armed forces at this time. Mr. McNutt recognizes the indispensable character of the physician for both military and civilian needs. He makes clear that eight states—New York, Illinois, California, Pennsylvania, Massachusetts, New Jersey, Michigan and Ohio—must supply most of the physicians needed for the armed forces at this time. Some of the states have already supplied so many physicians in proportion to their total medical population that recruitment in those states is to be discontinued now or in the near future."

A.M.A. Resolutions Re: Hon. Paul V. McNutt*

Dr. Charles H. Henninger, Pennsylvania, presented the following resolution, which was referred to the Reference Committee on Military Preparedness:

WHEREAS, There has come to this House of Delegates a message directly from the chief of the War Manpower Commission, Mr. Paul V. McNutt, indicating the needs of the nation in this great emergency for the services of the physicians of our country; and

* From minutes of proceedings of A.M.A. House of Delegates, Atlantic City session, June 9, 1942 and June 11, 1942. (See J.A.M.A., June 27, 1942, on pages 725 and 730.)

WHEREAS, The American medical profession has never failed in any previous emergency to meet the needs of the armed forces of our country for medical officers; and

WHEREAS, The Procurement and Assignment Service for Physicians, Dentists and Veterinarians was established by the President of the United States to enable the medical profession to meet all the demands placed on it to provide medical officers for all the governmental services, for industry and for our civilian population; therefore be it

Resolved, By the House of Delegates of the American Medical Association that we tender to Mr. Paul V. McNutt our appreciation of his message and of his cooperation; that we pledge to the President of the United States, to the War Manpower Commission, and to the Procurement and Assignment Service every aid that this organization can possibly render in meeting this objective, and that the Board of Trustees and the War Participation Committee of the American Medical Association be requested to give consideration to all of the means by which these objectives may be attained.

1 1 1

Report of Reference Committee on Military Preparedness

Dr. John H. O'Shea, Chairman, presented the following report, which was adopted on motion of Dr. O'Shea, seconded by Dr. William R. Brooksher, Arkansas, and carried:

Resolution on Message from Mr. Paul V. McNutt: Your reference committee recommends approval of this resolution, [see above] and that it be referred to the newly created War Participation Committee of the American Medical Association for continued action.

State Chairmen of the California Procurement and Assignment Service

By now, most physicians are aware that the medical division of President Roosevelt's War Manpower Commission has a national medical board of five, of which Dr. Frank Lahey—A.M.A. president in 1941-1942—is chairman; and that for each of the nine Army corps areas and the associated Navy districts there is a corps area chairman—in the ninth corps area, the late Charles A. Dukes, M.D., of Oakland, was succeeded by C.M.A. President, Henry S. Rogers of Petaluma; and further that in each of the seven Pacific States, composing the Ninth Corps Area, there is a State Chairman on Medical Preparedness Committee, the work of which is now being carried on under the "Procurement and Assignment Service." Philip K. Gilman, M.D., of San Francisco, and Chairman of the C.M.A. Council, was in charge of this work in the beginning, but when Captain Gilman went into active service in the U. S. Navy, with headquarters in San Francisco, the mantle was placed on the shoulders of Harold A. Fletcher, M.D., of San Francisco, who gave up his work as Chairman of the San Francisco Society Committee on Medical Preparedness, when he assumed his duties as State Chairman.

More recently, the Medical Preparedness Committees have practically been merged into the Procurement and Assignment Service. Because of the size and diverse interests of California, Dr. Fletcher found it desirable to have an Associate State Chairman, and for this work Edward M. Pallette of Los Angeles, who was Chairman of the Los Angeles County Society Committee, received appointment from Washington, to assume supervision of the work in the fourteen southern counties.

In every county of the State, a County Committee on Procurement and Assignment has been appointed, these being listed in the current issue of CALIFORNIA AND WESTERN MEDICINE.

Since the tasks which have been allocated to the two

State Chairmen on Procurement and Assignment—Doctors Harold A. Fletcher and Edward M. Pallette—will necessitate in many instances, interviews of a somewhat personal nature, the Editor has secured photographs of these two, well-known members of the California Medical Association, and the same are appended hereto, with some biographical data. The tasks assumed by Doctors Fletcher and Pallette and their associated County Committeemen, in furtherance of the objectives to which our Country is committed, are serious and heavy. The State and County Committeemen approach the solution of the problems they are respectively called upon to solve, with deepest appreciation of the interests of all concerned. Whole-hearted cooperation in their endeavors to carry on to Victory, is requested.

Some comments, now, concerning the two State Chairmen on Procurement and Assignment Service.

1 1 1



Harold A. Fletcher, M.D.
Chairman, California Procurement and Assignment Service

Harold A. Fletcher, M.D., a native of Michigan, was born on December 10, 1888. Preliminary schooling was in Berkeley. College education at University of Nevada and University of California, graduating in 1912. Medical education and internship at Stanford, 1916. Served in the last war, with Base Hospital No. 47, in San Francisco. Overseas for 10 months, in France. Entered practice of medicine in San Francisco after war, specializing in ear, nose and throat. Has been on teaching staff at Stanford since 1919. Now Clinical Professor in Surgery in the department of ear, nose and throat at Stanford. Is a member of the San Francisco County Medical Society; California Medical Association; Fellow of American Medical Association; member of the American Rhino-Oto-Laryngological Society. Member of the American Otological Society, Pacific Coast Oto-ophthalmological Society. Former chairman and vice-chairman of section of Ear, Nose and Throat Section of California Medical Association. President of San Francisco County Medical Society, in 1941. President of the San Francisco Chapter of the League for the Hard of Hearing.

Former chairman of Committee on Medical Preparedness of San Francisco County, chairman of California Medical Association Committee on Medical Preparedness, California State chairman of Procurement and Assignment Service for Physicians.

1 1 1



Edward M. Palette, M.D.
Associate Chairman, California Committee on
Procurement and Assignment

Almost a native son of California, Doctor Palette came to Los Angeles with his parents as a boy in 1889 and that city has been his home ever since.

Did his pre-medical work at Northwestern University in Evanston, graduating in 1894. Did graduate work in Biology and received his Master degree in '95. Received the degree of Doctor of Medicine from the College of Medicine, University of Southern California in 1898. Was for a short time in the Los Angeles City Health Department. In 1901-02 did graduate medical work in New York, London, Berlin and Vienna. Has practiced in Los Angeles since, giving special attention to gynecology. For a number of years was Professor of Physiology in the College of Dentistry, U.S.C., and taught histology and embryology in the College of Medicine.

Was President of the Los Angeles County Board of Education in 1898-99. Member of the Los Angeles City Board of Health, 1904-06, and of the California State Board of Health (Vice-President), 1932-40. Ex-President of the Los Angeles Obstetrical and Gynecological Society. President of the Los Angeles County Medical Association, 1918, and of the California State Medical Association, 1927. Was a Founder-Director, and is still Director-Treasurer of the Hospital Service of Southern California. Member of the Board of Trustees of the Medical Society of the State of California. Fellow of the American College of Surgeons. Has been a Delegate to the A.M.A. for the past ten years. Elected Trustee of the A.M.A. in 1942.* Chairman of Executive Committee of Medical Society of State of California. Served as Captain, Medical Corps, United States Army, World War I, at Letterman Hospital, San Francisco and at Camp Crane, Allentown, Pennsylvania.

Re: Medical Reserve Officers

A special drive for the recruitment of physicians who formerly held Army reserve commissions and either allowed them to lapse or resigned them rather than accept active duty has been started by Army officials. A list of those physicians who have resigned their commissions in the last two years is being prepared for this purpose, the list including close to 400 physicians for one section of California alone. The Army hopes, by using this list for medical recruiting work, to fill a large part of the California quota of some 1600 new medical officers by the end of 1942. Former holders of reserve commissions may obtain full information on the issuance of new commissions from the two Army Recruiting Boards in California.

C.M.A. MEMBERS IN MILITARY SERVICE**

Sacramento Society for Medical Improvement

Members of the Sacramento Society for Medical Improvement on Active Duty with the Army and Navy.

(Report, as of June 16, 1942. Total Number, 15.)

Name	Rank (if known)	Service (if known)
Adams, Elliott L.	1st Lieut.	Army
Babcock, Daniel W.	1st Lieut.	Army
Chambers, Jack V.	Lieut.	Army
Christian, Samuel	1st. Lieut.	Army
Day, Proctor W.	Lt. Comdr.	Navy
Dillon, Joseph, Jr.	Lieut.	Navy
Fuiks, Dellivan	Major	Army
Harding, William F.	1st Lieut.	Army
Isoard, Max C.	Major	Army
Kanner, Harry M.	1st Lieut.	Army
Phillips, Albert D.	Major	Army
Sarkisian, Milton V.	1st Lieut.	Army
Specker, Lewis	Captain	Army
Teall, Ralph C.	Captain	Army
Thomas, Bert S.	Lt. Col.	Army

San Diego County Medical Society

Members of the San Diego County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 9, 1942. Total Number, 42.)

Name	Rank (if known)	Service (if known)
Banks, G. F.	Captain	Army
Baxter, C. P.	Lt. Col.	Army
Bernardini, C. V.	Major	Army
Callaway, J. A.	Captain	Army
Chapman, H. J.	Lt. Comdr.	Navy
Churchill, A. G.	Lt. Comdr.	Navy
Colby, E. G.	Lt. Col.	Army
Cooper, A. J.	Major	Army
Egan, A. R.	Lieut.	Army
Eneboe, J. B.	Lieut.	Navy
Fetter, E. M.	Lieut.	Navy
Hanna, C. M.	Lieut.	Army
Harbaugh, O. S.	Major	Army
Hartsough, C. W.	Lt. Jr. Grade	Navy
Holder, H. G.	Major	Army
Hollander, F. G.	Lieut.	Army
Housvicka, O. A.	Lieut.	Army
Jetton, J. A.	Captain	Army
Laird, George	Lieut.	Navy

** County Society Secretaries are requested to submit the lists for their respective counties.

Lane, C. W.—Lt. Comdr.....	Navy
Lester, David—Lieut.....	Navy
Lindsay, C. V.—Captain.....	Army
Lounsberry, R. C.—Comdr.....	Navy
Lucic, Hugo—Lt. Comdr.....	Navy
Macpherson, F. L.—Lt. Comdr.....	Navy
Macpherson, J. D.—Lieut.....	Navy
Matson, J. R.—Lieut.....	Army
Minna, J. B.—Major.....	Army
Morris, G. W.—Captain.....	Army
O'Hara, F. P.—Lt. Comdr.....	Navy
Olds, John W.—Lt. Jr. Grade.....	Navy
Paull, Ross—Major.....	Army
Palevsky, S. N.—Lieut.....	Army
Present, A. J.—Lieut.....	Army
Robinson, F. H.—Captain.....	Army
Ryan, W. J.—Lt. Comdr.....	Navy
Seiler, W. E.—Lieut.....	Army
Svoboda, F. C.—Major.....	Army
Wedgewood, P. E.—Lt. Jr. Grade.....	Navy
Werden, D. H.—Lt. Comdr.....	Navy
Young, E. L.—Captain.....	Army
Zukovich, G. E.—Captain.....	Army

Santa Clara County Medical Society

Members of the Santa Clara County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 11, 1942. Total Number, 34.)

Name	Rank (if known)	Service (if known)
Anderson, Frank R.—Lt. Comdr.....	Navy	
Arminini, George B.—Captain.....	Army	
Campisi, Dominic A.—Captain.....	Army	
Carlson, Carl Oscar—Lieut.....	Army	
Chesbro, Wayne P.—Lieut.....	Navy	
Cook, Paul Enos—Lt. Comdr.....	Navy	
Cragin, Robert B.—Major.....	Army	
Cressman, Ralph D.—Captain.....	Army	
Francis, Kenneth V.—Captain.....	Army	
Gerstle, Mark F., Jr.—Lt. Comdr.....	Navy	
Haley, Philip S.—Lt. Comdr.....	Navy	
Hockenbeamer, Ernest P.—Lieut.....	Navy	
Ishikawa, Tokio—Lieut.....	Army	
Jenkins, Herbert T.—Lieut.....	Army	
Jorgensen, Melford B.—Lieut.....	Army	
Josephson, J. Bernard—Lt. Comdr.....	Navy	
Lane, Henry F.—Lieut.....	Navy	
Lawry, Edwin V.—Lieut.....	Navy	
Lee, Russell V.—Major.....	Army	
Liston, Edward—Captain.....	Army	
Lyon, Thomas P.—Captain.....	Army	
Lytle, Howard W.—Lieut.....	Navy	
Magoon, Leslie B.—Lieut.....	Navy	
Maher, Edward J.—Captain.....	Army	
Mitchell, Sidney P.—Lieut.....	Navy	
Moore, Ferrall H.—Lieut.....	Navy	
Norberg, Raymond W.—Captain.....	Army	
Pickworth, Max E.—Captain.....	Army	
Pritchard, Jacob L.—Lt. Col.....	Army	
Rogozen, Alexander—British Civilian Service		
Rouff, Elliot A.—Lieut.....	Navy	
Wood, Denniston, Jr.—Lieut.....	Navy	
Wood, George A.—Major.....	Army	
Wright, R. Wesley—Captain.....	Army	

Sonoma County Medical Society

Members of the Sonoma County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 6, 1942. Total Number, 8.)

Name	Rank (if known)	Service (if known)
Brink, Holden E.—Lt. Sr. Grade.....	Navy	
Clary, Raimond F.—Lieut.....	Army	
Congdon, Gordon H.—Lieut.....	Army	
Harr, Ralph V.—Lt. Comdr.....	Navy	
Hines, Leonard W.—Captain.....	Army	
Koerper, Victor E.—Lieut.....	Army	
Meyer, Emerson L.—Lieut.....	Army	
Quarry, Paul T.—Lieut.....	Navy	

Tulare County Medical Society

Members of the Tulare County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 6, 1942. Total Number, 7.)

Name	Rank (if known)	Service (if known)
Blasdel, E. K.—Captain.....	Army	
De Busk, Fred—Major.....	Army	
Falk, Harry—Major.....	Army	
Johnson, Cyril—1st Lieut.....	Army	
McKinnon, D. J.....	Army	
Powell, F. G.—1st Lieut.....	Army	
Zumwalt, Elmo—Major.....	Army	

Yolo County Medical Society

Members of the Yolo County Medical Society on Active Duty with the Army and Navy.

(Report, as of June 5, 1942. Total Number, 3.)

Name	Rank (if known)	Service (if known)
Gray, Earl—Major.....	Army	
Potter, Henry—1st Lieut.....	Army	
Robbins, Wilfred—1st Lieut.....	Army	

Military Clippings—Some news items of a military nature from the daily press follow:

Medics Warned They Must Meet War Emergency

America's physicians were told directly and bluntly yesterday that they must organize immediately to take over the emergency military and civilian medical needs of the nation—or else.

The "or else" phrase was laid down bluntly by Paul V. McNutt, Federal Security Administrator, in a brief and pointed address at Traymore Hotel before the House of Delegates of the American Medical Association at its opening meeting here.

Between now and Jan. 1, 1943, more than 3000 physicians will be needed every month to meet the growing needs of the Army and the Navy, he declared, and at present 5000 must be taken into service before July 1.

Raps 'Lack of Interest'

"There is an apparent lack of interest on the part of your profession to volunteer," he declared, because of reluctance to give up private income for Army pay. "That lack of interest is, in a large measure, based upon the failure to drive home to the average physician the magnitude of the need."

McNutt also declared that medical practice as it has been carried on before the war will be altered drastically—the first statement made by a government official on the much-disputed question of government regulated medical care.

He declared that in "boom defense towns" adequate medical care is vital to keep production lines moving and physicians will have a ready income now. However, the administrator declared, "their economy will certainly sag

after the war and there is need for government assistance to provide clinical equipment—facilities for medical care and otherwise to help in bearing the capital costs of servicing these communities”—after the war.

'Hard' Facts

McNutt added that he was not talking politics or social theory but "plain hard facts" of adjustment during this war and he told the physicians "it will have to be done on your basis, or another."

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Dr. Fred W. Rankin of Lexington, Ky., new president of the Association, declared later that medicine would meet this challenge. "War is now our principal business," he told the first general meeting of the Association. "Our profession is the trustee of the nation's health and as such its obligations are to furnish adequate medical care to the armed forces while at the same time maintaining faithful service to the civilian population and productive war industry installations."

During the war, he added, the medical profession will guard, maintain and even increase public health programs as the need becomes apparent. Dr. Rankin declared that the quality of medical care would not be impaired by the number of physicians being taken into the armed service.

He expressed this belief that in the present emergency physicians would work harder and longer and study harder than they ever did before on the problems of treatment of wounds and diseases.

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In his address last night as retiring president of the Association, Dr. Frank H. Lahey of Boston, declared that the present war will impose demands "which will tax the fortitude and complete resources of this country."

Never before in history have people been called upon for the sacrifices which will have to be made between now and the time the war is won. "As we look back over the past year and realize the alterations in our point of view I prophesy that the changes a year from now will make those of the past appear small in comparison," the Boston physician declared.

Profession to Be Drained

Pointing out that with a possible army of 7,000,000 to 10,000,000 men in uniform by a year from now there will be need for 50,000 to 65,000 physicians, he declared that "the sustaining of home care and institutions, the maintenance of medical attention for those employed in industry and the possibility of medical dislocation" present a challenge to the medical profession "not only in manpower but even more importantly in terms of the intelligence and efficiency with the situation is met."

Dr. Lahey agreed with McNutt in declaring that "although we have accomplished a great deal in altering the psychologic reaction of medicine to the urgency and magnitude of the situation, I feel certain that there are many individuals in medicine who have as yet not realistically appraised the need and the acuteness of the situation."... —Atlantic City Press, June 10.

* * *

Medical Profession Will Prove Mettle in War, A.M.A. Told*

Dr. Frank H. Lahey, of Boston, retiring president of the American Medical Association, declared yesterday that the present war may reverse present criticism of the medical profession.

The Boston physician, speaking at the A. M. A. conclave in Convention Hall, indirectly struck out at Thurman Arnold and other U. S. government officers who a year ago prosecuted the association for violation of the Sherman anti-trust law and obtained a verdict of guilty on grounds that it was a monopoly acting in restraint of trade. The case has since been appealed but no action on this appeal has yet been taken.

Forget Controversy, He Says

Dr. Lahey asked members of the association to forget this controversy because "the United States government has placed its complete trust in medicine in one of the greatest danger periods it has ever faced." Today's obligation, he added, is to first take care of the men and women who may be wounded abroad and at home.

"The critics of medicine who have accused us of decadence are eyeing this important undertaking in this dangerous period with very great interest. Its successful accomplishment will do more to give medicine an authoritative voice in post-war developments relative to possible

changes in medicine than any other thing which medicine can do." He added that the war work of physicians may "make supporters out of one's critics."

5000 Join Colors in 6 Months

Dr. Fred W. Rankin, the incoming president of the Association, declared that physicians were in step immediately after war was declared by Congress and during the past six months more than 5000 physicians and surgeons have joined the Army, Navy and Marine Corps.

Speaking before the opening meeting of the House of Delegates of the Association, the ruling body of American medicine, he declared that "we do share a responsibility for the fact that a sufficient number of physicians of proper age and capacity to care for the rapidly increasing needs of an expanding army has not been forthcoming."

Dr. Rankin said "this is a war of survival" and all other considerations must be forgotten. "We must understand that we fight with unscrupulous brutal enemies in a conflict whose technique by reason of motorized and mechanized equipment of warfare is not only an entirely new technique but one of savagery employed against both armed forces and civilian populations."

Retired Men Must Help

For this reason, he added, physicians who have retired must return to practice to fill the shoes of younger men being taken into service with the armed forces.

This movement is already under way, Dr. Rankin declared, with hundreds of retired physicians volunteering to take the places of men called into service. These men and women who are disqualified for military service because of age or physical deficiencies are doing remarkable service not only in private practice but also in incidental military duty when called on, he added.

Ten thousand physicians are attending the convention, which will continue through Friday.

Big Lack of Physicians

Dr. Rankin said there was still a tremendous lack of physicians to fill the blank files of the Army Medical Corps. He estimated at least 15,000 and perhaps 20,000 physicians would be needed before Jan. 1 to provide medical service for the Army now being recruited.

He added that many physicians have failed to register with the Procurement and Assignment Service organized by the government in cooperation with the American Medical Association. Every physician, he declared, should be registered with the service in the same way that he registers for the draft. . . . —Atlantic City Press, June 9.

* * *

All Physicians Under 45 Face Military Service

Twenty-seven dentists, the entire graduating class of the physicians and surgeons school of dentistry at San Francisco, will be commissioned first lieutenants in the United States Army Medical Corps at exercises Monday morning, according to the Associated Press.

Major F. Floyd South, commanding officer of the headquarters for medical recruiting in northern California, said the war department has decreed that all physicians and surgeons below the age of 45 and all dentists below 37, are potentially available for military service. After commissioning, they will be assigned to duty within a short time.—Sacramento Union, May 31.

* * *

Doctors Are Told They Must Take Over War Needs

Atlantic City, N. J., June 10.—(AP).—America's physicians were told directly and bluntly yesterday they must organize immediately to take over the emergency military and civilian medical needs of the nation—or else.

The "or else" phrase was laid down bluntly by Paul V. McNutt, federal security administrator, in a brief and pointed address before the House of Delegates of the American Medical Association at its opening meeting here.

Need 3000 Physicians a Month

Between now and January 1, 1943, more than 3000 physicians will be needed every month to meet the growing need of the army and the navy, he declared, and at present 5000 must be taken into service before July 1st.

"There is an apparent lack of interest on the part of your profession to volunteer," he declared, "because of reluctance to give up private income for army pay. That lack of interest is, in a large measure, based upon the failure to drive home to the average physician the magnitude of the need."

Will Alter Practice

McNutt also declared medical practice as it has been carried on before the war will be altered drastically—the first statement made by a government official on the much disputed question of government regulated medical care.

* By Stephen J. McDonough, Associated Press Staff Writer.

He declared that in "boom defense towns" adequate medical care is vital to keep production lines moving and physicians will have a ready income now. However, the administrator declared, "their economy will certainly sag after the war and there is need for government assistance to provide clinical equipment—facilities for medical care and otherwise to help in bearing the capital costs of servicing these communities" after the war.

McNutt added he was not talking politics or social theory but "plain hard facts" of adjustment during this war and he told the physicians "it will have to be done on your basis, or another."

Will Meet Challenge

Dr. Fred W. Rankin of Lexington, Ky., new president of the Association, declared later that medicine will meet this challenge. "War is now our principal business," he told the first general meeting of the Association.

During the war, he added, the medical profession will guard, maintain and even increase public health programs as the need becomes apparent. Doctor Rankin declared the quality of medical care will not be impaired by the number of physicians being taken into the armed service. —*Sacramento Bee*, June 10.

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Doctor Predicts Civilian Medical Care Will Be Cut

Army's Need For Physicians Is Likely to Cause Rationing

Boston, May 27.—(AP).—Dr. Frank H. Lahey, president of the American Medical Association, said last night the nation's civilian population must expect rationing of medical care because of the number of doctors needed in the armed services.

Urged to Enlist

Declaring virtually all physically fit doctors under the age of 45 are wanted in the services, and urging they enlist at once, Dr. Lahey told the Massachusetts Medical Society:

"As the situation becomes more acute and the endeavor more prolonged, there will be changes and modifications as to medical care, and the civilian population must without doubt adjust its lives as satisfactorily to these rationings as to the more tangible ones such as things to eat, wear and ride in."

Dr. Morris Fishbein, editor of the American Medical Association Journal, also advocated physically fit doctors under 45 to enlist, if their work could be taken over by others, because, he said, "You will be called anyway."

45,000 Doctors Needed

He said the army alone will require 45,000 doctors by the end of 1943.

Dr. John F. Fulton, Yale physiologist and aviation medicine authority, told the society's 161st meeting that 20,000 flight surgeons and aviation medical examiners will be required within a year by the nation's expanding army and navy air forces.—*Sacramento Union*, May 31.

* * *

Service Men Getting Best Possible Medical Care, Civic Clubs Informed

America's Army and Navy are the healthiest fighting forces in the world, get the best medical care from physicians farther advanced than any others, Dr. Perrin H. Long, head of the Department of Preventive Medicine at Johns-Hopkins University, declared yesterday. . . .

Dr. Long, in praising the health of the armed forces and medical technique, spoke from experience. He was one of the physicians who was flown to Pearl Harbor soon after the attack there, and in addition he drove 16,000 miles visiting military camps for the purpose of checking on health and medicine, as a representative of the Surgeons General of the forces.

Soldiers and sailors have escaped serious epidemics that civilians have suffered from, including influenza, scarlet fever and measles. Death rates are low and declining. It was notable, he said, that health was good in Army camps which had been hastily prepared and might have been expected to have unhealthful situations. In the numerous hospitals he visited at Army and Navy camps, he said, deaths were due to automobile accidents and similar accidents, almost none to infections.

Dr. Long told of the modern treatment of wounds, with "sulfa" drugs in Pearl Harbor and the amazing results. Soldiers and sailors who had to wait hours for operations were given temporary treatment with "sulfamiracles," the doctors' nickname for these new discoveries, and it prevented wounds from getting more serious.

He and an associate studied several hundred cases in Pearl Harbor and several weeks later checked them again when they were landed on the Pacific Coast. The remarkable recoveries checked with the first inquiries.

As a result of his investigations, and also from studies with research bodies set up by the Government, Dr. Long said that the American people can be assured that the fighting men are getting the best treatment medicine provides.

Dr. Long referred briefly to venereal diseases. As a matter of fact, he said, this is a civilian problem, not strictly an Army or Navy one. Modern treatment in these cases brings swift cures, but the causes of the disease are in the civilian communities and should be controlled by the civilians, Dr. Long declared. He said that he was certain the Army and Navy would gladly cooperate with any community that wanted to solve the problem, but emphasized that he was "quoting myself."

Despite the serious topic, Dr. Long managed to inject humor into his talk. Very amusing was his description of his plight when he was called upon to leave for Pearl Harbor on shortest notice. It was a secret mission and he had permission only to phone his wife that he would be away for an indefinite period, and goodbye.—*Atlantic City Evening Union*, June 10.

* * *

Army Shows Medical Corps Equipment

Atlantic City, N. J., June 10.—(AP).—The Army Medical Corps exhibited for the first time today its new equipment to save the lives of thousands of soldiers during the present war.

Foreseeing the need of rapid transportation to keep up with fast-moving mechanized forces, the Army has developed field hospital units which can be set up and torn down faster than the circus moves in and out of town. One of the chief components of this quick-service unit is a new type ambulance capable of carrying a maximum of 21 men in comfort at speeds up to 50 miles per hour.

Other equipment demonstrated to physicians at the ninety-third annual meeting of the American Medical Association included a complete snow set, including everything from skis and snowshoes to emergency first aid supplies which one soldier can carry on his back.

Army medical officers said that within a short time sulfanilamide or sulfathiazole powders may become a standard part of the equipment of every soldier so that when hit he can immediately treat a wound.

The Army's panzer medical units are going to require increasing quantities of blood plasma in the war effort, Dr. Earl S. Taylor of the American Red Cross told the Association and as many as 2,000,000 Americans may be asked to give their blood.—*San Francisco Chronicle*, June 11.

* * *

Physically Unfit to Be Rehabilitated

The greatest medical, dental and surgical rehabilitation program in the history of the country will be in full swing by summer.

That this progressive nation had to be forced into such a campaign by the necessity of war is an indictment on our good sense. As belated as it is, however, this campaign is of vast importance to the welfare of humanity.

About 200,000 men otherwise fitted for army duty require extensive dental repair work. They are to get it at the expense of the army and the selective service system.

They may go either to their private dentist or to a dentist selected from an approved list. In such a case the bill will be paid by the selective service system. Or the man can go into the army and have the dental work done by army dentists.

A similar rehabilitation procedure will apply to registrants who need surgical or medical repair that does not require too much time.

The program has been started in Maryland and Virginia as testing grounds. When sufficient experience has been gained it will be extended to the rest of the country on the largest possible scale commensurate with the equipment and dental and medical personnel available.

That 200,000 men of military age are unfit because of need of dental or surgical attention is the result of lack of proper public clinics. The war has focused attention on this and other glaring defects in our social system. The post-war period will be marked by demand for correction of such weak spots in our civilization.

Socialized medicine may not be the answer, but at least government is to indicate a greater interest in the health of the people.—*San Bernardino Sun*, May 24.

* * *

Greater Need for Doctors in War Work Bared

Civilians Urged to Reduce Demands on Physicians

Chicago, June 24.—(INS).—Preventable illness and unreasonable demands on the time of physicians must be reduced to a minimum because of the urgent need for

physicians for the armed forces, Paul V. McNutt, chairman of the War Manpower Commission, warned tonight.

In a statement published in the current issue of the *Journal of the American Medical Association*, McNutt pointed out that the recruitment of physicians has lagged behind expected quotas. He warned that unless voluntary recruitment progresses more rapidly, some more vigorous form of selective service must be resorted to.

City Areas Lag

"The case is urgent," McNutt stated.

"In fairness to the recruitment record of many of our States," he wrote, "it seems in order at this time to give the (medical) profession some further idea of how its problem is distributed. The failure of a sufficient number of physicians to volunteer for military service is not spread thinly over the whole country. There is an acute lag in populous States. Other States have supplied nearly all they should supply.

"We need more than 20,000 additional physicians by the end of this year. But eight States—New York, Illinois, California, Pennsylvania, Massachusetts, New Jersey, Michigan and Ohio—should account for nearly 16,000 of that shortage."

Bottlenecks Cited

The *Journal* in the same issue reviewed the situation as pictured by McNutt and commented, in part:

"The medical profession cannot be accused of failure to play its part in every way in relationship to the war effort. Every one who is participating in the recruitment of physicians recognizes that there have been bottlenecks to be cleared away as the effort has progressed."—San Francisco *Examiner*, June 25.

* * *

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Committee on Public Health Education Basic Science Initiative: On November Ballot

The Basic Science Act has passed its first test; it has qualified for the November election with the filing of 230,179 valid signatures, or some 18,000 more than the legal requirement of 212,117.

This act will be Proposition Number 3 on the November election schedule.

So far, so good. We have accomplished what we set out to do in qualifying this measure. Now we have the more strenuous and all-important job of passing it. We need a majority of the votes cast in November to put this measure on the statute books. More than half of all those who vote in November must register a "Yes" vote on Proposition Number 3 if we are to have the higher standards of practice envisaged by the Basic Science Act.

Boiled down to practicalities, this means that every member of the profession must get out and work for the passage of the Basic Science Act. This must be a campaign where every individual gets behind the bill and pushes. There are numerous ways in which this can be done, and at the proper time these ways will be suggested to you. There will be ample management of the campaign, but management will fall down without a supporting organization. The part of every physician will be in the organization on the fring line.

Right now there is no request to be made of you except that you keep in mind the benefits to be gained by the passage of the Basic Science Act and make sure that everyone with whom you talk does not leave you with any antagonism to the bill. Wage a protective conversational campaign at this time; do not start out on a

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

crusade to gather votes, but rather keep your ears open for adverse comments which you can correct immediately. When the time comes, you will be asked to solicit favorable votes. At that time your efforts will be urgently needed and asked for.

With your help, California may gain the benefits of higher standards of practice that already obtain in 16 states and the District of Columbia where Basic Science Acts are now in effect.

* * *

Medical Bill Qualifies for November Ballot

Examiner Bureau, Sacramento, June 24.—Submission of petitions bearing 165,376 signatures from Los Angeles County today qualified a basic science initiative measure for the November general election ballot.

The proposed act, sponsored by both the California Medical and Dental Associations, would establish a new board of examiners in basic sciences which would conduct examinations in these fields for applicants for licenses in the various healing-arts. Candidates successfully passing board examinations would then apply to the board of medical examiners or other licensing agencies for permits to practice.

Deputy Secretary of State Charles J. Hagerty said the Los Angeles filings brought to 230,179 the number of valid signatures filed in behalf of the measure, against 212,117 necessary to qualify it.

With the deadline for initiative and referendum measures tomorrow midnight, only two other issues have qualified thus far for a place on the ballot. One is the referendum on the legislative "hot cargo" bill and the second is the new building and loan act qualified for the ballot during the legislature's battle over the Pacific States Savings and Loan Company.—San Francisco *News*, June 25.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Long Beach Home Defense Show

The Council of Civilian Defense of Long Beach, California, early this spring recognized the need of a well informed civilian population for the efficient functioning of any civilian defense program.

In spite of the fact that much publicity had been given to the individual's responsibility in the event of a war emergency; in spite of the numerous educational programs presented by the various agencies in the defense set-up; the people of that city, just like the people of all other cities of this country, failed to recognize generally that home defense is really a matter of individual responsibility and knowledge of what to do.

The Long Beach Council of Civilian Defense to bring this knowledge dramatically to the mass of the people, presented a Mammoth Home Defense show at the Municipal Auditorium, May 15, 16 and 17.

Sixty-two different agencies connected with civilian defense took part in this ambitious Exposition.

Demonstration booths filled the lower floor and the foyer of the Auditorium. Doctor Fred B. Clarke was director of these demonstrations, which included everything from methods of extinguishing incendiary bombs to the operation of blood banks.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Dwight H. Murray, Napa; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M. D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

More than 40,000 citizens of Long Beach visited the Auditorium during the three days of the show and obtained practical first hand information that prepared them better to cooperate with the constituted authorities in the program of civilian defense.

Capacity audiences of 4800 witnessed each of the four stage presentations given in the Convention Hall of the Auditorium. The principal feature of this presentation was a two-act play, written and directed by S. K. Cochems, Executive Secretary of the Los Angeles County Medical Association, and entitled, "It May Happen Here."

The first act of this play presented a typical Long Beach home during an air raid, which ended with several typical casualties within the home and offered the opportunity to demonstrate what should and should not be done within the home during a raid. Members of the Community Players of Long Beach made up the cast for this act.

The second act presented a typical Long Beach Casualty Station where the casualties developed in act one were taken care of. The following Doctors of Medicine acted the part of casualty station physicians in the second act: Drs. Arthur Buell, Ward Hannah, R. Brisbine, Walter N. Caseley, H. A. MacMillan, and C. C. Cole.

Because of the large size of the Convention Hall, the greater part of the acting was pantomime with rather elaborate sound effects. Mr. Cochems, as commentator interpreted this pantomime, in terms of educational value to the audience.

The Long Beach Home Defense Show received, naturally, a great deal of important publicity in Long Beach. The wire services, recognizing this show as something new in civilian defense programs, carried the story far and wide throughout the country.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Postgraduate Institutes on Industrial Hygiene

(COPY)

WELFARE DIVISION, M.L.I.C.

William P. Shepard, M.D.

Assistant Secretary

Pacific Coast Head Office

600 Stockton Street, San Francisco, California

June 16, 1942.

George H. Kress, M.D.,

Secretary, C.M.A. Postgraduate Committee,
San Francisco, California.

Dear Doctor Kress:

(1) This is written in my capacity as Chairman of the Educational Committee, Western Association of Industrial Physicians and Surgeons, and reports to you progress to date on our proposed series of special Institutes on Industrial Hygiene to be held throughout the State for the benefit of physicians in industry.

You will recall that we planned to have these institutes sponsored jointly by the California Medical Association Committees on Industrial Hygiene and Postgraduate

Activities; by the California State Department of Health; and by the Western Association of Industrial Physicians and Surgeons.

(2) Doctor Bertram P. Brown, Director, State Department of Health, has approved our proposed budget and forwarded it to the United States Public Health Service. We have every reason to think that this item will be approved, but cannot be certain until about July 10. Meanwhile, however, we are proceeding with all possible details.

(3) Since there is great urgency in this matter, we hope to have the series of institutes take place between August 3 and 12, inclusive. A tentative schedule is enclosed.

(4) We are already informed of the availability of Doctor Carey P. McCord, Medical Advisor, Chrysler Corporation, Detroit, and have a tentative acceptance from Doctor Leroy U. Gardiner, Director, the Saranac Laboratory, New York. We also expect the assistance of either Mr. Donald E. Cummings, Director of Industrial Hygiene, Colorado Medical School, an industrial hygiene engineer of national prominence, or Mr. J. J. Bloomfield, Chief Industrial Hygiene Engineer, United States Public Health Service, Washington, D. C. In addition, the faculty will include Doctor Robert T. Legge, Professor of Hygiene, University of California; Doctor Harold T. Castberg, Chief of Industrial Hygiene Service, State Department of Health; Mr. Carl Frey, State Industrial Compensation Board; a leading traumatic surgeon from each area; a leading industrialist, and a local engineer.

(5) May we rely on you to send notices of these meetings over the name of the Committees on Postgraduate Activities and Industrial Hygiene to County Society members in the counties surrounding each meeting place? We can discuss the exact mailing list and form of the invitation any time at your convenience.

(6) Since there is every reason to anticipate that this program will go through as planned, would you care to make some mention of it in the forthcoming issue of CALIFORNIA AND WESTERN MEDICINE? Please let me know if you wish further information.

Sincerely yours,

(Signed) W. P. SHEPARD, M.D.,
*Chairman, Educational Committee,
Western Association of Industrial
Physicians and Surgeons.*

(COPY)

State of California

DEPARTMENT OF PUBLIC HEALTH
Sacramento

June 29, 1942.

*The Members of the County Medical Societies,
Addressed.*

Dear Doctors:

This is a preliminary announcement to inform you that plans are under way for a series of special Institutes on Industrial Medicine, one of which will be held in your locality on the date shown below. They are sponsored jointly by the Committees on Postgraduate Activities and Industrial Practice of the California Medical Association; the Western Association of Industrial Physicians and Surgeons; and the California State Department of Public Health.

These institutes are intended to assist physicians devoting part time or full time to medical practice in industry. They will be short, concentrated sessions, occupying only one afternoon and evening, presenting several leading national authorities with opportunity for discussions and questions. Enclosed is a sample program, still in tentative form, but illustrating the type of session.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

This is a coöperative endeavor for the benefit of our country. With younger physicians being called into the armed forces, more of the older men will be called into industry. Great opportunities lie in this field since the health of the worker is as important to victory as the health of the soldier. Many physicians will wish to brush up on industrial medicine and this is their opportunity to do it. Even though it may conflict with one afternoon's office hours, we hope no one interested or engaged in this field will miss this opportunity. There is no expense involved except the price of the dinner which will be nominal.

Please call these institutes to the attention of your interested members. Exact meeting place will be announced later. The schedule is as follows:

- August 18—San Francisco.
- August 19—Crockett.
- August 21—Oakland.
- August 24—San Diego.
- August 26—Los Angeles or vicinity.
- August 27—Glendale.
- August 28—Huntington Park.

About a month preceding each meeting, Doctor Harold T. Castberg, United States Public Health Service, Acting Director, Industrial Hygiene Service, State Department of Health, will call on the President and Secretary of the county society in which the meeting is to be held to discuss details and arrangements. Your assistance and coöperation will be deeply appreciated.

Sincerely yours,

BERTRAM P. BROWN, M. D.,
Director of Public Health,
State Department of Public Health.

GEORGE H. KRESS, M. D., *Secretary of*
Committee on Postgraduate Activities,
California Medical Association.

BENJAMIN M. FREES, M. D., *President,*
Western Association of Industrial
Physicians and Surgeons.

SUGGESTED PROGRAM

- 2:00 p.m.—*Opening of the Institute*
President of County Medical Society
- 2:10 p.m.—*Introduction*
Purposes and methods of the Institute—Sponsors and Participants. General Field of Industrial Hygiene and its values to practicing physicians.
Robert T. Legge, M. D.
- 2:25 p.m.—*The Conservation of Industry's Man Power*
Specific instruction about the general field of medical relationships in Industry; the part played by the practicing physician as an advisor to industrial management in organizing and administering a full-time or part-time medical department.
Carey P. McCord, M. D.
- 2:50 p.m.—*Industrial Hygiene and War Production*
Mr. Donald E. Cummings or
Mr. J. J. Bloomfield
- 3:05 p.m.—*Pulmonary Diseases in Industry*
Mr. Donald E. Cummings
- 3:25 p.m.—*Occupational Diseases in California*
With special references to diseases common in the locality of the Institute; demonstration of apparatus and methods used in making an industrial survey.
Harold T. Castberg, M. D.

3:55 p.m.—*California Industrial Accident Commission*
Mr. Carl Frey

4:15 p.m.—*The Surgical Management of Industrial Injuries*
Doctor Howard (North)
Doctor Frees (South)

4:45 p.m.—*General Discussion*

6:30 p.m.—*Informal Dinner*

8:00 p.m.—*Health in Industry*
Colonel Clarence M. Young,
Pan American.

8:20 p.m.—*Health Problems of Women in Industry*
Carey P. McCord, M. D.

8:40 p.m.—"Save a Day"—U.S.P.H.S. new motion picture

9:00 p.m.—*General Panel Discussion and Question Box*
Carey P. McCord, M. D.
Harold T. Castberg, M. D.
Mr. Donald E. Cummings or
Mr. J. J. Bloomfield
Leroy U. Gardiner, M. D.
Mr. Carl Frey
Doctor Howard or Doctor Frees
Robert T. Legge, M. D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM...Asst. Chairman on Publicity

President Hund's Address: At Annual Session*

As representative of the Woman's Auxiliary to the California Medical Association, I greatly appreciate the privilege of the floor for these few minutes.

The doctors of the California Medical Association have been very kind to the Auxiliary, but I feel that some do not quite understand our aims and objectives, and the things that we are trying to accomplish.

Where the Medical Societies have asked the County Auxiliaries to carry on some definite work, it has made for a stronger Auxiliary and a better friendship between the women and among the doctors themselves.

I ask you, doctors, who live in sections where there are no County Auxiliaries, to consider us seriously. Look into our aims and objectives, and realize that this is an unselfish organization.

Our membership has increased in spite of the fact that many doctors have been called into the service, which often has necessitated change of residence by their wives. There are 2,142 members to date, and three new Counties have been organized, Inyo-Mono, Mendocino-Lake and Siskiyou. This leaves eight Medical Societies without Auxiliaries.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

* Address of Mrs. Harry O. Hund, President of the Woman's Auxiliary to the California Medical Association. Given at the first general session of the California Medical Association, Del Monte, May 4, 1942.

To the Advisory Council of the California Medical Association, and Mr. Hunton, I am truly grateful; for they have been most helpful and ready to give kindly advice whenever we called upon them.

Now, I would like to refer briefly to some of the activities we have carried on during the past year.

Due to the war emergency, many projects have had to be added to those which have been carried on during previous years.

Work vital to Civilian and Home Defense, and Red Cross had to be taken up and carried on.

A "survey" of all of our members has been made classifying them into four groups:

1. Those who have had training in nursing.
2. Those who have had training in clerical work, medical secretarial work, nutrition, anaesthesia, x-ray and other special work.
3. Those who have had no training, but who would be interested in First Aid, Nurses Aid and Chemical Warfare.
4. Those who have had training in foreign languages, and would be willing to work with State and Federal Agencies.

Each Auxiliary is to keep a file of this data, which we hope will be of benefit to the Medical Profession in case of an emergency.

Having speakers on "Nutrition for Health Defense" was stressed, and was publicized to lay organizations.

We aided with the procurement of signatures for the Basic Science Initiative, but regret that the result was not better; a cause being that the petitions were sent out to us too late and in several cases the Auxiliaries did not receive them at all.

In Defense Work:

Fully 95 per cent of the Auxiliary members are active in Red Cross, Civilian Defense and all branches of the war emergency work.

Up to 20,000 hours have been given by three counties to Red Cross work.

A total of 20 counties report that Auxiliary members are instructors and heads of Red Cross units.

Some 15 Auxiliaries have planned for a work-day each week at the local Red Cross chapters.

A total of 3,980 hours have been given for work at the blood banks.

One county donated \$114.00, secured 250 donors and took over the blood bank. Another county gave 2,000 hours at their blood bank. The members of one of our smaller and newer counties have established a blood bank, and are assisting the doctors in its operation.

\$750.00 has been given for Medical Scholarships.

\$441.13 has been donated to Red Cross and War Relief.

\$200.00 has been given to Health Agencies.

\$150.00 to Hospitals and Sanitariums.

Apart from the Auxiliaries providing programs and entertainment for the men in the service outside of the Hospitality Houses, they have taken over specified days at the U.S.O. Houses, and sent Christmas trees, food and books to them.

Our members have been asked to interest lay people in the radio broadcast sponsored by the American Medical Association, "Doctors at Work."

The work on the Control of Cancer has gone ahead under the direction of the State Chairman.

Three Auxiliaries have reached their quota for Hygeia and one received honorable mention.

This year, for the first time, we have had a State Medical Benevolence Chairman. The problem of raising funds was placed before the Auxiliaries and the result has been gratifying.

Los Angeles County has contributed \$276.00 to the Physicians' Aid of Los Angeles, but the rest of the

counties have sent their contributions directly to the State Auxiliary.

Before closing, I wish to present, in the name of Auxiliary, this draft for the sum of \$735.00 to you, Dr. Rogers, as President of the California Medical Association, to be used as the Association may see fit for its Medical Benevolence Fund.

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County Auxiliary News Items

Humboldt County.—The last meeting of the season was held by the Humboldt Auxiliary on June 1st, at the home of Mrs. B. M. Marshall.

Mrs. David McInturff, treasurer, gave a report on the proceeds collected from the play readings, which were given by Mrs. Gordon Manary to raise funds for the American Red Cross War Relief.

The week of July 6th was chosen as the time in which the Auxiliary members will act as hostesses to the local U.S.O.

The following officers were elected for the year 1942-43: Mrs. John S. Chain, Jr., President; Mrs. B. M. Marshall, Vice-President; Mrs. Max Todd, Secretary; and Mrs. Walter W. Dolfin, Treasurer.

* * *

Los Angeles County.—The last luncheon meeting of the year of the Woman's Auxiliary to the Los Angeles County Medical Association was held Tuesday, May 26th, in the County Medical Building.

Guests of honor were Dr. William R. Molony, President of the California Medical Association; Dr. Lowell Goin, Speaker of the House of Delegates; and Dr. Elizabeth Hohl, Chairman of Physicians' Aid Association.

A check for \$277.00, procured by voluntary contribution of Auxiliary members, was presented to Dr. Hohl for the Physicians' Aid Fund.

New officers were elected and installed in an impressive ceremony, and flowers, brought by the members from their own gardens, and arranged, decorated the luncheon tables.

* * *

San Diego County.—San Diego County Auxiliary is proud of the five women elected to serve on the State Board for the coming year. Mrs. F. G. Lindemulder will assume the presidency of the State Board.

On Tuesday, May 12th, Past Presidents of the Auxiliary, as well as recently-elected State Officers from the San Diego Auxiliary, were honored at luncheon at the University Club.

* * *

San Francisco County.—The May meeting of the San Francisco County Medical Auxiliary was an important one, in that it was the day on which the new officers were installed for the year 1942-1943. Mrs. J. C. Geiger, a Past President, installed the new officers with a very gracious talk on the accomplishments of the Auxiliary to date. President, Mrs. Raleigh Burlingame; First Vice-President, Mrs. William Newman; Second Vice-President, Mrs. Frederick Fellows; Treasurer, Mrs. Paul Michelson; Recording Secretary, Mrs. Harold Rosenblum; Corresponding Secretary, Mrs. Sydney Shipman. After this ceremony was completed, the retiring President was presented with a corsage as a gesture of appreciation for the great work which she has done in the year. Doctor Chauncey D. Leake, Professor of Pharmacology, University of California, spoke in a very interesting and informative way on War Gases.

The Auxiliary was requested by a group of the Medical Society, interested especially in nutrition, to have an additional meeting this year to concern itself with this vital subject. The meeting will be on Tuesday, June 9th, and the speaker will be Doctor Ann Purdy, Chairman

of the San Francisco Nutrition Council. Her subject will be "Nutrition." Miss Hazel Stevens, national authority on Posture, will speak on this subject. Guests invited are the wives of doctors at present in the armed forces around San Francisco. Tea will be served.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (64)

Alameda County (10)

John R. Booth, *Oakland*
Ellen Brown, *Berkeley*
George D. Brown, *Oakland*
George T. Honaker, *San Leandro*
Jonas J. Moyer, *Oakland*
Fenton Parker, *Oakland*
Walton Prescott, *Oakland*
John Stewart, *Oakland*
A. Ralph Thompson, *Berkeley*
John M. Ward, *Oakland*

Inyo-Mono County (1)

Walter R. Schatz, *Death Valley*

Los Angeles County (24)

Alan Calder Adams, *Beverly Hills*
Lewis H. Athon, *Los Angeles*
Samuel C. Benadom, *Beverly Hills*
Herschel S. Burns, *Los Angeles*
James Willoughby Burton, *Los Angeles*
Don McCauley Curtis, *Los Angeles*
Clarence Arnold Dahl, *San Pedro*
Roger John Dugan, *Los Angeles*
Edward Alfred Franklin, *Los Angeles*
Victor Goldberg, *Long Beach*
Dell Dean Haughey, *Los Angeles*
Earl Granville Longley, *Long Beach*
Saul Moss, *Los Angeles*
Rudolph Woldemar Mueller, *Los Angeles*
A. Victor Nasatir, *Los Angeles*
James Edgar Nichols, Jr., *Glendale*
Harold Owens, *Los Angeles*
John Lawson Saur, *Glendale*
Ralph Varian Sloan, *Glendale*
Erwin Edward Stephens, *Los Angeles*
John Daniel Stroud, *Pomona*
Robert Grant Thornburgh, *Long Beach*
William B. Wenz, *Lynwood*
Joseph B. Williams, *Los Angeles*

Sacramento County (5)

Abe E. Berman, *Sacramento*
George E. Chappell, *Sacramento*
Donald A. McKinnon, *Sacramento*
William R. Murphy, *Sacramento*
Kenneth E. Overholt, *Folsom*

San Bernardino County (1)

Wayne M. Caygill, *Lake Arrowhead*

San Francisco County (14)

William G. Barrett, *San Francisco*
Kenneth L. Elges, *San Francisco*
Olive F. Erickson, *San Francisco*
Gerald G. Gill, *San Francisco*
William A. Gorman, *San Francisco*
Alexander Gradow, *San Francisco*
James A. Hamilton, *San Francisco*
Emily L. Koeniger, *San Francisco*

Sanford E. Levy, *San Francisco*
Stanley Louie, *San Francisco*
Frank Norris, *San Francisco*
Henry William Scott, *San Francisco*
Clement A. Tavares, *San Francisco*
John B. Thielen, *San Francisco*

San Joaquin County (1)

Virginia Wright, *Stockton*

Santa Clara County (6)

Herbert T. Browne, *Palo Alto*
Carl O. Carlson, *Ft. Ord*
Ernest F. Elmore, *San Jose*
Philip J. Jordan, *San Jose*
Vasco A. Salvadorini, *San Jose*
W. Elwyn Turner, *San Jose*

Shasta County (2)

Charles William Brown, *Redding*
Leonard Katz, *Burney*

Transfers (6)

Maurice F. Stock, from Fresno County to Los Angeles County
Denson Basil Wheelis, from Riverside County to Los Angeles County
Victor Hart, from Siskiyou County to Alameda County
Albert Velarde, from Lassen-Plumas-Modoc County to Alameda County
William A. Richardson, from San Bernardino County to Los Angeles County
George E. Webster, from Sonoma County to Los Angeles County

Retired Members (5)

Maynard C. Harding, *San Diego County*
E. Jay Clemons, *Los Angeles County*
Arthur A. Libby, *Los Angeles County*
William Owen Sheller, *Los Angeles County*
Leon H. Watkins, *Los Angeles County*

In Memoriam

Dyke, Louis Henry. Died at Oakland, June 2, 1942, age 65. Graduate of the Oakland College of Medicine and Surgery, 1916. Licensed in California in 1916. Doctor Dyke was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Gunderson, Harley James. Died at Los Angeles, May 29, 1942, age 53. Graduate of Northwestern University Medical School, Chicago, 1911. Licensed in California in 1926. Doctor Gunderson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Hall, Giles S. Died at San Francisco, June 4, 1942, age 73. Graduate of Rush Medical College, University of Chicago, 1897. Licensed in California in 1898. Doctor Giles was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



McCullough, Frank Edward. Died at Sacramento, June 4, 1942, age 63. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1879. Licensed in California in 1906. Doctor McCullough was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

†For roster of officers of component county medical societies, see page 4 in front advertising section.

Shafor, Harry Andrew. Died at Westwood, May 27, 1942, age 66. Graduate of Eclectic Medical College, Cincinnati, 1899. Licensed in California in 1926. Doctor Shafor was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Pearson, Charles E. Died at Turlock, May 23, 1942, age 64. Graduate of Kentucky School of Medicine, Louisville, 1898. Licensed in California in 1918. Doctor Pearson was a member of the Stanislaus County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



Clark, Vernon Greene. Died at San Diego, June 6, 1942, age 69. Graduate of Missouri Medical College, St. Louis, 1896. Licensed in California in 1906. Doctor Clark was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



OBITUARIES

George Chauncey Wrigley, M. D.
1884—1942

Dr. G. C. Wrigley, for thirty years a practising physician and surgeon in Sonora, California, and a member of the San Joaquin County Medical Society, was found dead on the floor of his office Friday morning, May 1. He had failed to return home the night before, and his wife became anxious, as he had been suffering from a heart ailment for several weeks. Accompanied by his office nurse, she discovered the body; where it was evident that, in falling, he had struck his head on an iron operating table, causing a fracture of the skull.

Dr. Wrigley was a native of New Brunswick, Canada, and spent his earlier life in Eureka, California, where he went through the public schools. He was graduated from the College of Physicians and Surgeons of San Francisco in 1909; and after a short period of practice in San Francisco, moved to Sonora where he has been continuously engaged in professional work, except for a period during the first World War, when he served in the medical corps.

Dr. Wrigley, during his long residence in Sonora, earned the confidence of many people who would wait patiently for his return to practice, since they felt no one else could quite take his place.

He is survived by three daughters and a son, who is now in the armed forces of the United States, three brothers and two sisters, living in Eureka, California.

DEWEY R. POWELL, M. D.



Louis Montrose Haight, M. D.
1868—1942

On Monday morning, April 27, Louis M. Haight, one of the oldest members in our San Joaquin County Medical Society, was found dead in bed, having passed away quietly in his sleep. Dr. Haight had spent the previous day, Sunday, working about his garden, and had enjoyed a family dinner before retiring. His son spoke to him at 7:00 o'clock A.M. and apparently he had had a usual night's rest; but at 9:30 he failed to respond to a call to breakfast, having passed away.

Dr. Haight was born in Alameda, California, October 7, 1868. He was the son of Henry Huntley Haight, who at that time was Governor of the State of California, and served in that capacity from 1867 to 1871. One of the principal thoroughfares in San Francisco, Haight Street, was named in honor of the Governor.

After preliminary education in the public schools of Alameda, Dr. Haight attended Yale University, where he graduated with the Class of 1889. He returned to California, and in 1897 was graduated from the College of Pharmacy of the University of California. After following that profession for three years, he entered the Cooper Medical College and was graduated with the Doctor of Medicine degree in 1903.

He spent several years in the City and County Hospital in San Francisco under private practice, and moved to Stockton in 1906 to devote his time to ranching interests. In 1917, when a number of the medical men in practice in Stockton volunteered their services in the armed forces of the United States, Dr. Haight resumed his medical career, working for a while in the offices of Dr. Ellis Harbert. He later continued practicing by himself and was active up to the time of his death at 73 years of age.

Dr. Haight was married in 1900 and his widow and three sons survive. His oldest son, Cameron, is now professor of Chest Surgery at the University of Michigan Medical School at Ann Arbor, and has made a splendid record in his chosen specialty. His second son, Herbert, is manager for the Shell Oil Company in Seattle, Washington. His third son, Huntley, is employed by the United States Government in Stockton.

At all times Dr. Haight was most courteous and considerate as a gentleman. It was my privilege to have his friendship for a period of thirty years, and for many years recently he has been my neighbor. Through all the twenty-five years in which he resumed the practice of medicine, his greatest pleasure was still to watch things grow, and his garden was his delight. He was also a great lover of music, and thoroughly enjoyed singing in various men's choral groups.

He will be sorely missed by his multitude of friends and the many patients who placed their confidence in his judgment.

DEWEY R. POWELL, M. D.



Giles Starke Hall, M. D.
1869—1942

Dr. Giles S. Hall was born March 3, 1869, on a farm north of Ionia, Michigan. He died in the Southern Pacific General Hospital in San Francisco, June 4, 1942.

He attended public school in Ionia, the Maryland Military Academy, and completed his medical course at Rush Medical in 1897.

Dr. Hall first came to Los Angeles in 1887, then returned East to complete his education. He began the practice of medicine in the County Hospital at Tombstone, Arizona; later became surgeon for the Phelps-Dodge Company, and was licensed to practice in the state of Sonora, Mexico, where he spent four years.

He married Louise Hobbie of Omaha, Nebraska, in 1901. They lived in Mexico until 1903, at which time they returned to Los Angeles where the doctor soon became associated with the Los Angeles and Pacific Electric Railways, and in 1904 with the Southern Pacific Company. For many years he has been Assistant to the Chief Surgeon in charge of the Los Angeles office of the Southern Pacific Medical Department.

Dr. Hall was a man who kept in close touch with the developments of modern medicine; he was a member of the Los Angeles County, California State, and American Medical Associations. He was Past President of the Pacific Association of Railway Surgeons. He enjoyed life and was greatly beloved by his family and his associates. His keen sense of humor was in daily evidence in his contact with friends and patients, and those of us who have been associated with him for many years will greatly miss him.

RUSSELL W. STARR, M. D.

OBITUARIES

Vernon Greene Clark

1872—1942

Dr. Vernon Greene Clark, county hospital assistant superintendent and a San Diego resident for 36 years, died of a heart attack on June 6th.

Born in Steelville, Mo., in 1872, Dr. Clark was graduated from the Washington Medical college in St. Louis, Mo. After taking several postgraduate courses, he went to Colorado, where he practiced in many mining camps.

Dr. Clark came to San Diego in 1906 and began a private practice. He served in World War I as a lieutenant commander, U.S.N. After the Armistice, he resumed his private practice, continuing it until three years ago, when he joined the county hospital staff. He was a former president of the San Diego County Medical Society.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

November, 1940.....	19,990
May, 1941.....	27,057
November, 1941.....	32,199
May, 1942.....	38,061

The job of converting our full coverage contracts over to the two visit deductible has begun. This is in line with the policy which was recently laid down by the Board of Trustees of California Physicians' Service.

As previously reported, the full coverage contract has not been successful in producing an adequate return to the physician. Our experience with the two-visit deductible has shown that some of the human factors that have destroyed the full coverage are taken care of.

Several groups have already been contacted, and we have had very interesting reactions from the people involved. It is interesting to note that the beneficiary members of C.P.S. are just as anxious to make the plan go as the medical profession is, and are perfectly willing to abide by the changes that we have suggested.

Since we will be contacting every group throughout the state, there will be an opportunity that we have not had in the past of reacquainting these groups with the objectives of the medical profession, and reestablishing satisfactory public relations, which is one phase of our activities with which, to date, we have been able to do very little.

It is felt that with the proper understanding on the part of the groups, and with the increasing return to the physician, many of the basic troubles of C.P.S. will automatically disappear.

* * *

Tulare Bureau Members Told of Hospital Plan

Visalia (Tulare Co.), May 30.—Dr. H. B. Rector of Fresno, field representative for the California Physicians' Service, which is negotiating a contract with the Tulare County Farm Bureau for treatment of bureau members, further outlined the proposed plan during the week.

Dr. Rector said the annual dues for one person is \$22.50; for two in a family, \$36; three, \$45; four, \$51; five, \$54.50, or six or more, \$57.

† Address: California Physicians' Service, 153 Kearney Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of non-profit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

List of Services

The services offered in the contract follow:

All medical and surgical services that may be necessary as a consequence of illness or injury. In the office of a California Physicians' Service professional member. In the home when necessary. In the hospital when necessary.

All x-ray and laboratory examinations necessary in the opinion of the attending professional member are included.

Obstetrical services.

Chronic ailments and/or conditions, unless contagious or infectious and acutely emergent, shall receive only such services as are necessary to establish prognosis or estimate of ultimate value of treatment; except:

Can Extend Treatment

In the cases of members who have not reached their nineteenth birthday upon favorable prognosis the medical director of the service shall authorize such continued treatment as he deems necessary.

In the cases of members who have passed their nineteenth birthday and who are wage earners of the family, chronic conditions which interfere with earning capacity may receive necessary care upon the approval of the medical director of the service.

Service Is Limited

Surgical service for each member who has passed his nineteenth birthday shall be limited to surgical service for such conditions as are proximately caused after 12 o'clock noon of the day upon which the service issues a certificate of beneficiary membership to him, and then only after such consultation as the medical director of the C.P.S. may require.

The farm bureau also is contemplating a contract with the Hospital Service of Southern California. The hospital rates are:

A maximum of \$24 for three or more members of a family annually to a minimum of \$7.50 for a single male and \$9.60 for a single female.

Hospital Care Provided

The hospital care is provided in any of the sixty-one member hospitals in Southern California as follows:

Twenty-one days per year for each particular physical disability arising from a separate and distinct cause. Services will be provided in a room of three or more beds.

All meals and dietary services.

General nursing care.

Use of operating room as often as needed.

Surgical and anaesthetic supplies.

Splints, casts, dressings.

All necessary drugs except biologics, endocrines and vitamin preparations, and oxygen.

Existing conditions fully covered.

Obstetrical cases covered with a maximum of \$5 per day for a period of ten days hospitalization after ten months waiting period.

Childbirth Provisions

Obstetrical care is provided only to wife under a family contract and after ten months' membership. Hospital care does not cover diseases declared by law to be quarantinable, pulmonary tuberculosis after diagnosis, mental disorders nor diagnostic or rest cure hospitalization.

Surgical service for obstetrics is furnished only for ectopic pregnancies and Caesarean sections, when medically necessary.

Neither the hospital service nor the surgical service covers conditions already protected by any workmen's compensation or employers' liability laws or conditions caused by war.—Fresno Bee, May 31.

* * *

Farm Health Association in Second Year

The North Coast Farmers' Health Association began its second year of operation on June 1. This cooperative health program was organized last year under the leadership of the Farm Security Administration, by a group of farm families in Sonoma, Lake, and Mendocino Counties. An agreement was made with the California Physicians' Service to promote medical care and hospitalization for the members at a fixed prepaid fee. Seventy-five families joined the association. A similar agreement has been signed for this year, with about the same number of families participating. At membership meetings held last month, directors elected were S. C. Farwell of Santa Rosa, Don Milliken of Cotati, Helmuth Tornoe of Sebastopol, Mrs. William Peters of Hopland, and Glenn Dickey of Lakeport.

Although the membership year started June 1, additional applications will be received up to June 25. Any farm family, whose net income is less than \$2000.00,

and who wishes the assurance that its medical needs are provided for, is invited by the directors to join the association. Full details may be obtained from any of the directors, or from the local office of the Farm Security Administration, 501 Rosenberg Building, Santa Rosa.—*Healdsburg Tribune and Enterprise*, June 11.

* * *

Signup Date Is Set For Rural Hospitalization

Oroville (Butte Co.), June 8.—Claude Lane of Gridley, President of the Butte County Farmers Health Association, has announced that June 13th has been set as the last date upon which new members can join the group.

The association, Lane said, has started its second year of operation in Butte County, and through the California Physicians' Service, has provided almost complete medical, surgical, obstetrical and hospital care for low income farm families who are members. The member has the privilege of selecting her own doctor. To be eligible, Lane said, the farm family must make at least 50 per cent of its income from farming and farm labor, and the net income must not exceed \$2000.00.

Lane said that after June 13th, there will be no opportunity of joining the association until June, 1943.—*Sacramento Bee*, June 8.

REVISED LIST OF REPORTABLE DISEASES

(Reportable to the California State Board of Public Health)

Reportable Only:

Anthrax
Botulism—if commercial product notify State Department of Health at once.
Coccidioidal Granuloma
Dengue—keep patient in mosquito-free room.
Epilepsy
Food Poisoning
Glanders—report by phone or telegraph.
Jaundice—infectious or epidemic types.
Malaria—keep patient in mosquito-free room.
Pneumonia—specify type of pneumococcus, if known.
Relapsing Fever
Pneumatic Fever
Rocky Mountain Spotted Fever
Tetanus
Trichinosis
Tularemia
Undulant Fever

Reportable and Subject to Isolation:

Epidemic diarrhea of the newborn (in institutions)
Chickenpox
Dysentery—Amoebic
Dysentery—Bacillary—specify type, if known.
German Measles
Influenza
Measles
Mumps
Ophthalmia Neonatorum
Psittacosis
Rabies—in animals. Use special card.
Rabies—in humans.
Septic Sore Throat (in epidemic form).
Trachoma
Tuberculosis—use special card.
Whooping Cough
Syphilis—use special card.
Gonorrhea—use special card.
Chancroid—use special card.
Lymphopathia Venereum—use special card.
Granuloma—Inguinale—use special card.

Reportable and Subject to Quarantine and Placarding:

Cholera—report by telephone or telegraph to State Department of Health.
Diphtheria
Encephalitis (Infectious)—specify type if known.

NOTE: This means all forms of acute encephalitis such as St. Louis type, equine type, and any other epidemic form occurring in California.

Leprosy

Meningitis (due to the meningococcus).

Paratyphoid Fever—specify type A or B.

Plague—report by telephone or telegraph to State Department of Health.

Acute Anterior Poliomyelitis

Scarlet Fever

Smallpox

Typhoid Fever

Typhus Fever

Yellow Fever—report by telephone or telegraph to State Department of Health, State Office Bldg., Sacramento.

DYSENTERY CARRIERS

Since it is only slightly absorbed into the blood stream, succinylsulfathiazole, a sulfonamide compound, is much less likely to produce severe toxic or poisonous reactions than sulfaguandine in the treatment of dysentery carriers, William M. M. Kirby, M. D., and Lowell A. Rantz, M. D., San Francisco, report in *The Journal of the American Medical Association* for June 20. They found succinylsulfathiazole to be as effective in treating dysentery carriers as sulfaguandine and is ineffective in treating typhoid carriers.

WARN HIGHLY FATAL FUNGUS DISEASE IS NOT CONFINED TO CALIFORNIA

Coccidioidal granuloma in human beings is a chronic, highly fatal fungous disease affecting the lungs, skin, lymph nodes, bones, meninges, the organs of the chest, and other body tissues. In a paper in *The Journal of the American Medical Association* for July 4 on the incidence of the disease in man and animals, George W. Stiles, M. D., and Charles L. Davis, D.V.M., Denver, warn that, while the disease "has been considered peculiar to California, its appearance both in man and in animals from other localities indicates that the malady is either spreading or has not heretofore been recognized. Coincident with this disease in man, an increase is noted in the number of cases occurring in lower animals. In regions in which man has acquired infection, cattle, dogs, sheep, wild rodents and possibly other animals may harbor the fungus.

"Coccidioidal granuloma appears to be acquired by inhaling spores of the fungus, by cutaneous [skin] infection through wounds or rarely through the gastrointestinal route."

EFFECTIVE TREATMENT FOR AN EYE DISEASE

The direct application of a 5 per cent ointment of sulfathiazole or sulfathiazole sodium was effective in causing rapid healing in 11 of 15 cases of inclusion conjunctivitis in infants, children and adults, Phillips Thygeson, M. D., and William Stone Jr., M.D., New York, report in *The Journal of the American Medical Association* for May 30. In 10 of the 11 cases the virus could no longer be found after the third day of treatment. Two of the remaining 4 cases, 1 in a child and 1 in an adult, required supplementary treatment by mouth; the remaining 2 cases, both in infants, failed to heal until the mothers learned to employ the medication properly. There were no recurrences. Untreated cases of the disease take from four to six months to heal.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.

American Medical Association, San Francisco. Date of 1943 Session not yet decided.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Few things are more important to a community than the health of its women. If strong is the frame of the mother, says a proverb, the son will give laws to the people. And in nations where all men give laws, all men need mothers of strong frames.—*T. W. Higginson.*

Opportunities for Physicians: Traumatic Surgery.—

The Receiving Hospital Department for the City of Los Angeles has announced that many of their ambulance and hospital doctors have joined the armed forces. Doctors interested in emergency traumatic injury work should contact the Chief Surgeon, Dr. Wallace Dodge, at 1337 Georgia Street, Los Angeles, California.

Doctors of Medicine as Some Others See Them.—

During recent years, the medical profession and its work,

has been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest. Several of such excerpts follow:

1 1 1

Fewer Doctors.—Thousands of doctors are being called into military service, and from now on there will be fewer of them to care for our aches and pains. The fighting forces need them.

The list of doctors in Riverside and Riverside county—those within the military draft age—is growing smaller and smaller on the home front, and we are going to find it more and more difficult to be served.

There is little question of dependency, in the case of our doctors, because all doctors are commissioned officers, with salary sufficient to take care of families at home modestly but adequately.

Few of us appreciate how many physicians are being siphoned off into the armed forces and how great an added burden this imposes on the doctors who remain at home. A doctor who remains at home will be required to take care of a great many more patients, than in the past. We know the doctor will do his best. But there are only so many hours in the day and it will be up to the patients to help him along as much as they can.

Few realize that continued good medical service will depend on helping the doctor to conserve his time. The more time the doctor can save in traveling about to see his patients the more time he will have to treat them. Don't ask the doctor to make house calls when you are perfectly able to go to his office. Don't expect him to sit around and talk about extraneous matters. Don't try to turn a professional visit into a social occasion.

The American people are used to the best medical service on earth—and they will continue to receive that kind of service if they give due consideration to the fact that the doctor is one of the busiest of men.

Families with pioneering traditions will know what it is to get along with few calls from the doctor. They will be more careful about themselves and their children, under conditions which face them, and most of them will be better off for being too busy to worry about their small aches. No more easy care for trifling illness. They'll give themselves a first-aid treatment and go on from there. They'll have to.

What we must do is to listen carefully to the doctor's instructions, get them right the first time and follow orders accurately.—*Riverside Enterprise*, May 19.

Save Independent Medicine.—We do not hear much agitation for socialization of medicine these days. Our system of private medicine has been responsible for so many great achievements that demands for revolutionary changes are not given the support of thinking people.

However, proposals are occasionally made which, though they may seem superficially sound, would extend a measure of political control over medicine which would pave the way for socialization or regimentation of the doctor at some future date.

A recent example of that is found in the proposal that the Social Security Laws be broadened to make health

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

insurance compulsory for all workers and their families.

If this proposal were made into law, the doctor would have to look to the insurer, a branch of Federal government, for much of his livelihood. The insurer would determine the fees which he might charge and that, in turn, would determine the amount of time he could give each patient. The future of all doctors would depend, in part, on a bureau whose policies and personnel are directly affected by the ever-changing tides of politics. And, most important by far, if compulsory sickness insurance became a national policy, the logical next step would be the passage of a law making everything concerned with public health a function of the state. And that would be nothing more or less than socialized medicine.

If private medicine had failed, a case could be made for this. But the plain truth is that America has been a world leader in care of the sick and in medical discovery. The man with little or no money can command the finest medical talent, and the most famous doctors give much of their time to patients who cannot pay. What valid reason can there be for disrupting a system which has given the American people the finest average health on earth?—*San Jose Santa Clara County Review*, June 9.

Rationing Doctors.—The warning voiced to the American Medical Association the other day that the nation's civilian population must expect rationing of medical care will be seized upon by the confirmed heckler who likes to borrow trouble as a field for almost endless speculation over the practical difficulties of administering such a rationing program.

Will they give us so many calls a month, sick or well, he will wonder? Or will we be entitled to medical attention for only one ailment, with all the others left to run their natural course? And will there be special X-cards for hypocondriacs, ailing dowagers and congressmen? Will you have to prove you are essential to the war effort before you can get some attention?

The heckler who asks all these questions, of course, will be missing the essential point—which is that rationing of civilians for medical care, however accomplished, will be preferable to having to ration the armed forces.

The plain fact is that there aren't enough doctors to meet the needs of the army and navy, and to continue giving civilians the care to which they are accustomed. This was brought home rather sharply at the A.M.A. meeting, where it was estimated that 45,000 doctors will be required by the army alone before the end of the year.

Thus, it is the old story of civilians having to sacrifice the luxury of medical service that is not entirely necessary, so there will be enough to go around for essential needs.

We have no idea how the practical obstacles to rationing of medical care can be surmounted, but we have no doubt that some system can be found to handle civilian cases in the order of their importance instead of first-come-first-served if the situation becomes critical enough to warrant it.

And we would rather suffer through our minor aches and ailments without medical care, if we knew that by so doing we were making it possible for our over-worked family doctor to save the life of either a wounded soldier or one of the neighbor's children.—*San Jose Santa Clara County Review*, June 9.

Ready for Any Eventuality.—"The indications are

that the needs of the Army, the Navy, public health and civilian populations can be met by scientific planning and complete coöperation without any deterioration in the quality of medical education and medical service," said the Journal of the American Medical Association, recently.

War makes heavy demands on American medicine. Thousands of doctors are being called to duty with the military forces. Tens of thousands of doctors are giving a part of their working time to the Selective Boards and other military and quasi-military agencies. Workers in arms industries will work longer hours at strenuous labors, and will require more medical attention than was necessary in peacetime. But, despite all this, experts in the field are convinced that American medicine will meet the crisis with complete success.

That is a fine testimonial to our system of private medicine. Nowhere else in the world are doctors given such rigorous training. Nowhere else in the world are there so many doctors. Nowhere else in the world has such astonishing progress been made against the bacterial killers. The average American is healthier than the average citizen of any other country. He lives a longer, happier life. And you can give American medicine much of the credit for that.

The American hospital system has kept pace with the medical progress. To meet wartime needs, increased hospital facilities are being planned in many regions. Those who guard this nation's health are doing a magnificent job—and they are ready for all eventualities.—*Stockton Pathfinder-Union*, May 15.

1 1 1

Saga of the Small Town Doctor:

That, in brief, is the saga of all small town family physicians in America since this nation was founded. That, too, is the life story of the man whose soul has just departed and to whom this inadequate tribute is belatedly paid. He has done all of these things and more.

Somehow or other, this particular physician's grip upon the lives of his flock continued from the moment of the first pulse beat until they were laid to rest. Their attraction to him began in childhood and grew stronger with the years. Their faith in him grew with the passing of each day. So great was this faith that many seemed to defy the irresistible hand of fate in their final moments, expecting him to pull them through as he had done so many times before.

Physician, counselor, humanitarian, friend—this man was all these and more. His cheerful witticisms became legendary. His buoyant personality drove despair from sick rooms. His knack of accurate diagnosis, coupled with unerring treatment, gained for him prestige in his profession. His diplomatic frankness conveyed to others in a gentle manner the picture as his adroit, experienced eyes saw it, not as he would have preferred it to be. The families of the ill knew they could rely on this and acted accordingly.

This man was the friend of all. No one left him empty handed when it was within his power to help. His generosity was so proverbial that it was imposed upon. Such imposition, when known, brought forth no criticism from his lips. And yet, withal, he was a real he man, enjoying association with his fellowmen of all stations in life. No one was too lowly or too proud to be called by him a friend and in turn to call him a friend.

That the world is a trifle better for the life and deeds of this genuine physician would seem self-evident. That such men live on—forever—in the hearts of their fellowmen is likewise self evident. And that somewhere, somehow, someday—in that great beyond from whose bourne

no traveler returns—we shall be reunited by death, is the faith that sustains us in our moments of bereavement.—*Merced Sun-Star*, June 2.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Election of Trustees of the American Medical Association

Edward M. Pallette of Los Angeles Elected Trustee

Dr. William R. Molony, Sr., California, nominated for Trustee to succeed Dr. Arthur W. Booth, Elmira, N. Y., whose term has expired and who is not eligible, according to the By-laws, for reelection, Dr. Edward M. Pallette, Sr., Los Angeles, and the nomination was seconded by Drs. Charles E. Mongan, Massachusetts; William Weston, Section on Pediatrics; James M. Hayes, Minnesota; Joseph F. Smith, Wisconsin; E. S. Hamilton, Illinois; Robert L. Anderson, Pennsylvania; Hilton S. Reed, New Jersey, and E. E. Barlow, Arkansas.

Dr. Thomas A. McGoldrick, New York, placed in nomination the name of Dr. Charles Gordon Heyd, New York.

It was moved by Dr. William A. Mulherin, Georgia, seconded by Dr. L. W. Larson, Section on Pathology and Physiology, and carried, that the nominations be closed.

The tellers spread the ballot and the Secretary announced that 139 votes had been cast, of which Dr. Edward M. Pallette, Sr., received 104 and Dr. Charles Gordon Heyd, 35. The Speaker declared Dr. Edward M. Pallette, Sr., Los Angeles, elected Trustee for a term ending in 1947, to succeed Dr. Arthur W. Booth. On motion of Dr. Thomas A. McGoldrick, New York, seconded by Drs. George W. Kosmak, New York, and Robert A. Peers, California, and carried, the vote for Dr. Pallette was made unanimous. . . . —From Minutes of Proceedings of A.M.A. House of Delegates, in *Journal of the American Medical Association*, June 27, 1942, page 731.

* * *

Doctors Gather for A. M. A. Convention

Atlantic City, June 8. (INS).—With problems of the war paramount on the program, more than 13,000 delegates gathered today for the American Medical Association's annual convention.

Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, pointed to one of the chief war problems facing the physicians when he declared that 20,000 young doctors are needed for America's military service this year, in addition to the 22,000 already commissioned.—*Pasadena Star-News*, June 8.

* * *

Atlanta Doctor Named A. M. A. Head

Atlantic City, N. J., June 12.—(AP).—Dr. James E. Paullin of Atlanta, Ga., will take office next year as president of the American Medical Association.

Dr. Paullin, chairman of the association's council on scientific assembly, was named president-elect yesterday by the A.M.A.'s house of delegates, ruling body of American medicine. He will succeed Dr. Fred W. Rankin of Lexington, Ky., who took over as president Wednesday night.

Dr. William J. Carrington of Atlantic City was named vice-president; Dr. Olin West of Chicago was reelected secretary; Dr. Herman L. Kretschmer of Chicago was named treasurer; Dr. H. H. Shoulders of Nashville, Tenn., speaker of the house, and Dr. R. W. Fouts of Omaha, Neb., vice-speaker; Dr. Edward M. Pallette, Los Angeles, trustee.

The group decided to meet at New York in 1945. Next year's meeting, that of 1943, will be held in San Francisco.—*Oakland Tribune*, June 12.

* * *

A. M. A. Distinguished Service Medal

Dr. Ludwig Hektoen Named by Association

Atlantic City, N. J., June 8.—(UP).—Dr. Ludwig Hektoen, 78, Chicago, won the American Medical Association's 1942 distinguished service award today for outstanding contributions in the field of medicine.

The award was announced by the association's house of delegates at the 93rd annual convention opened. Dr. Hektoen, leader in the field of pathology, is chairman of the advisory committee of the National Cancer Institute and chairman of the committee on scientific research of the A. M. A.

The award includes a citation and a medal and is the highest honor bestowed upon a member by the association.

Dr. Hektoen had not arrived today for the convention, but is expected here tomorrow.—*San Francisco News*, June 8.

* * *

Physicians Told of Discoveries at A. M. A. Meeting

Baldness and Virility

Atlantic City, June 9.—(AP).—A form of ammonia found in the common pitcher plant of Eastern swamps, one shot of which relieves certain types of deep-seated pain for days or weeks, was described to the American Medical Association here today.

Another report related that baldness in men was definite evidence of possession of an abundance of he-hormones. This finding was submitted to the association for the study of internal secretions, meeting in conjunction with the medical association.

The baldness report was by Dr. James B. Hamilton, Yale University School of Medicine. He found that men who had lost their normal supplies of male sex hormones tended not to become bald, even in families where baldness was the rule.

When some of these men were given male sex hormones, they started to lose their hair; stopped losing it when the hormone was taken away.

He concluded that two factors influenced baldness, one an inherited predisposition, the other the male hormone stimulation.—*Oakland Tribune*, June 9.

* * *

That Seashore 'Lift' Is Thalassotherapy; Says So

'Right Here'

Atlantic City, N. J., June 9.—(AP).—Did you ever wonder what's the name of that "lift" people get during visits to the seashore?

It's thalassotherapy.

Says so right in the American Medical Association's convention program.

Dr. Charles I. Singer of the Long Beach (N. Y.) Hospital has an exhibit on thalassotherapy at the convention.

His display is designed to show:

1. That 35,000,000 Americans take undirected vacations each year are motivated by "whom, vogue or hearsay" as to where's the best place to go.

2. That as a result they meet up with climatic changes which are either stimulating or sedative.

3. That many people who have chronic ailments may benefit by medical direction while they are basking at the seashore—especially children with catarrh, asthma, tuberculosis, rickets and retarded development; adults with neurasthenia, chronic arthritis and hay fever.

4. That it's a fallacy to say you get worse sunburns on a hazy day than a bright one.

5. That there's more iodine in the air at the shore.

6. That feet cut on shells at the seashore rarely become infected because the sun-baked sand is clean.

7. That sunstroke is rare on beaches, and heat prostration virtually is unknown because the infra-red rays are partly absorbed by the skin.

8. That thalassotherapy is the treatment of disease by a resident at the seashore, or by sun-bathing.—*Oakland Tribune*, June 9.

* * *

The Blood Bank, a Monument

Today the San Mateo county blood bank went into service on the grounds of the Junior college, a testimonial to the community coöperation of scores of individuals and firms and particularly of Union labor which sponsored the movement and did most of the pioneering.

The dedication today was marked by a public program in the spirit of the gift itself, where speakers told of its importance to the community and gave credit to those responsible for its being here. The audience was also introduced to the two persons symbolic of the blood bank itself and who, appropriately, volunteered to give the first blood. They were Mr. U. S. Simonds, Jr., of the Carpenters' Union and Miss Helen Chesebrough, of the San Mateo County Red Cross. Mr. Simonds first suggested the county blood bank, and his suggestion was taken up by Union labor. As its importance became evident the county and scores of individuals became interested, contributing what they could best give, whether money or material, service or labor.

The blood bank will be here and will be available to save the life of anyone in the county. The efficacy of blood plasma in saving life in case of violence or burns has long been known but was demonstrated beyond all doubt at Pearl Harbor when hundreds of boys who otherwise would have been doomed to a quick death, were saved and are even now back in the firing lines.

Opening of the blood bank is an important step in the medical history of the county.—*San Mateo Times and Leader*, May 23.

Hospital Note—Don't Linger

Oakland, Calif. (AP).—Hospitals here are trying to shorten the length of their patients' stay, to be better equipped for war emergencies. It is hoped to cut the average from ten to nine days, largely by dismissing maternity cases earlier than usual.

Private institutions are running virtually at capacity, owing to increased population springing from defense factories and partly to hospital service plans.—*Monrovia News-Post*, May 18.

* * *

Dr. Mark L. Emerson, county coroner of Alameda County, has filed his nomination papers in preparation for a reelection campaign this year.

Dr. Emerson is a graduate of the University of California, former school director and health officer of the City of Oakland, former director of the Alameda County Mosquito Abatement District, and past president of the Alameda County Medical Association.

Elected four years ago, Dr. Emerson established the coroner's office in a county-owned building for the first time. During his four years in office he has established deputies in outlying communities and has improved the efficiency of the office.—*Oakland Tribune*, June 9.

* * *

Strong War on Plague Urged

Must Be Extended to Protect Army Camps, Officials Aver

Washington, June 4. (AP).—Public health officials testified before the house appropriations committee during hearings on the service's appropriation for fiscal 1943 that the fight against bubonic plague must be extended this year because of the need to protect army camps and to prevent the eastward spread of ground squirrels which carry the disease.

Dr. J. W. Mountin said that each year the service encountered about a dozen deaths from plague throughout the United States and that hunters and campers who shot the rodents could become infected.

He said the infection was known to exist among squirrels and other rodents in the 12 mountain and Pacific coast states.

Dr. Mountin said that if the rat population of the cities became infected, human deaths would become more numerous and he recommended the establishment of rodent-free zones around towns, cities and military establishments, saying such measures were especially urgent from a military point of view. He said plague-infected rodents had been found on the grounds or in the immediate vicinity of Fort Warren, Wyo.; Fort Wingate, New Mexico; McCarran Field, Nevada; Camp Hunter, Liggett, Calif.; Fort George Wright, Washington; Geiger Field, Wash.; Gowen Airfield, Boise, Idaho, and at the Pendleton, Ore., Airfield.—*Ogden Standard-Examiner*, June 4.

* * *

Birth Control Urged for WAAC Volunteers

Margaret Sanger Says Army Should Furnish Scientific Information to Protect Its New Corps

New York, June 3.—Now that Women's Army Auxiliary Corps, that has started recruiting, has ruled women who are going to have babies will be discharged from the Army, Mrs. Margaret Sanger, founder and honorary president of the Planned Parenthood Federation of America, says: "It is up to the Government to furnish Army women with scientific contraceptive information and not force them to rely on backfence gossip or folklore.

"This should not be made a religious issue. It should be as protective to a WAAC's security as vaccination secures her against smallpox," Mrs. Sanger said today.

"If the Army heads have allowed themselves to get into this position without thinking it through the whole way the dishonor is on their side and not on the woman's. In my estimation child-bearing is never a dishonorable function.

"I believe the WAAC is perfectly right in making the ruling. While some women even in the Army could carry a baby up to the eighth month without feeling any discomforting effects, they are few. The Army cannot pick and choose. It has to make a policy. If they let any one come in and have her babies it would be too insecure for the Government.

"It is up to the woman to decide whether she wants to go in the Army or have her baby. She has no right to do both. A woman should definitely make up her mind which she wants.

"Babies are not the problem of the woman's army in England because since 1932 women there have had access to birth control information," she said.

Mrs. Sanger believes that birth control advice should be given to those who need it most.

"The average married woman should have the right to get contraceptive information, but this should be given by the right authorities," Mrs. Sanger emphasized, and pointed out that three states, North Carolina, South Carolina and Alabama—now have birth control services as part of their state health control.

Dr. Pierce recalled that in 1937 the American Medical Association stated doctors had a legal right to give contraceptive information to women. Last fall in Washington, he stated, the Public Health Service agreed to consider child planning programs submitted by states on the same basis that they would consider any other health measure.

Mrs. Sanger said she recently interviewed 10 women whose husbands were going off to war. Eight of the 10 said they were going to have babies. Each gave the same reason.

"She wanted to have a baby by the man she liked." —*San Francisco News*, June 3.

* * *

Old Birth Control Ban Upheld

Connecticut's High Court Backs Law Against Practice

Hartford (Conn.), June 3.—(AP).—Upholding Connecticut's 63-year-old anti-birth control law for the second time in two years, the State supreme court ruled in a three to two decision today that it was illegal for a physician to advise a married woman to use contraceptives even when bearing a child might cost her life.

The case arose from a request by Dr. Wilder Tileston of Yale medical faculty, for a declaratory judgment as to whether the law prohibits a licensed physician from prescribing contraceptives for married women in cases where pregnancy would endanger life or health and, if so, whether the law is constitutional.

Both prescribing contraceptives and the use of them to avoid conception are criminal offenses under Connecticut law, but a physician can perform an abortion upon a married woman, if necessary to save her life.—*San Francisco Examiner*, June 4.

* * *

Supreme Court: Oklahoma Sterilization Law Is Ruled Unconstitutional

Washington, June 1. (AP).—Declaring that important questions of human rights were involved, the Supreme Court held unconstitutional today an Oklahoma law for the sterilization of certain habitual criminals.

The court struck down the statute because it singled out only certain types of criminals. Such "clear, pointed, unmistakable discrimination" was called as "invidious as if it had selected a particular race or nationality for oppressive treatment."

The act provides for the sterilization of men or women thrice convicted of felonies but specifically excepts "offenses arising out of the violation of the prohibitory laws, revenue acts, embezzlement or political offenses."

The case at issue involved Jack T. Skinner, 34, of Pittsburgh county, Oklahoma, who was convicted once of stealing chickens and twice of armed robbery and ordered in 1937 to be sterilized. The court pointed out that Oklahoma treats larceny and embezzlement the same as far as fines and prison terms are concerned and that if Skinner had embezzled the chickens as an employee of the owner instead of stealing them as a stranger, he would not have been subject to sterilization.

This situation, said the majority decision by Justice Douglas, violates the fourteenth amendment to the constitution which guarantees all citizens equal protection of the laws. There was no dissent, but Chief Justice Stone and Justice Jackson wrote separate concurring opinions.

"We are dealing here," Douglas writes, "with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race."

The court some years ago upheld a Virginia law for the sterilization of feeble-minded persons in State institutions. Twenty-seven States have laws for compulsory sterilization of "defective persons." Nine of them, California, Delaware, Idaho, Iowa, Nebraska, North Dakota, Washington, Oklahoma and Oregon, provide for sterilization of "habitual criminals," with varying definition of that phrase.—*San Francisco Chronicle*, June 2.

* * *

Spare the Doctor

Few realize the tremendous strain imposed on the medical profession by the war.

So many doctors have been drawn into war service

that those remaining in civilian practice find themselves able to keep pace with civilian requirements only by extending their efforts to the greatest degree.

As time and the war progress the shortage of medical service will become even more acute, and we all would do well, therefore, to heed the plea to "Spare the Doctor" issued by the San Francisco Medical Association.

The patient may help the doctor materially in extending his usefulness, the association points out, by going to the doctor's office rather than asking the doctor to call at the home, and by making calls as brief as possible and as infrequent as the patient's condition will permit. —San Francisco *Call-Bulletin*, June 9.

* * *

Mother's Consent to Operation Necessary

Washington High Court Divides, Upholds Parental Veto

Olympia, Wash., June 11.—Upholding state laws governing custody of a child, the Supreme Court today decided 6 to 3 that with the mother of Patricia Hudson, 11, rests the only authority to grant doctors permission to amputate the girl's arm.

The case was taken to the Supreme Court after Superior Judge William G. Long of Seattle ruled in favor of Patricia's four brothers and five sisters, who approved the operation. The girl's left arm, according to physicians, is ten times the size of her normal right arm and may result in death within a few years.

The girl's mother objected to the operation because she feared the operation might cause death. Doctors stated there is a fifty-fifty chance that the operation will prove successful and prolong the girl's life.

In reversing the lower court, the Supreme Court ruled that unless custody of the child was awarded to another guardian, the child could not be subjected to a surgical operation without the mother's consent.—Los Angeles *Daily-Journal*, June 12.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

San Francisco

Operations Without Consent; Emergencies Created By War Conditions

IT IS a rule of very general application that a physician or surgeon who operates upon a person without his consent, express or implied, is guilty of an assault in the absence of extenuating circumstances, and must respond to the person operated upon in damages to compensate for any loss occasioned by such an unauthorized operation. Where a patient is in full possession of his faculties and in such physical health as to allow consultation with the physician or surgeon with respect to his condition, his consent is a prerequisite to even a minor operation if the physician or surgeon involved is to avoid liability for unforeseen damaging results of the operation.

Another ramification of this general rule is that the patient must be legally capable of giving his consent, and at this time two classes of persons are recognized by the law as being incapable of giving such consent, i.e., minors and mentally incompetent adults. (For a full discussion of operations upon persons legally incompetent to consent to same, see the Medical Jurisprudence

article in the March, 1939, issue of CALIFORNIA AND WESTERN MEDICINE, Vol. 50, No. 3.) Consent to the performance of operations upon these persons must be obtained from those legally qualified to give such consent, in the case of a minor from his parents, if living, or from his duly-appointed guardian, and in the case of mental incompetents from their guardians.

These are the general rules applied in court actions brought by a person claiming to have been operated upon without his consent and injured thereby, but they are varied from time to time and a physician or surgeon is protected when he acts in cases of emergency to save life or limb. Also, in many cases, the courts will find from the facts that the patient has given his "implied consent" to the operation.

The rule is stated in *48 Corpus Juris*, at page 1131, that where an emergency arises calling for immediate action for the preservation of life or health of the person, and it is impracticable to obtain his consent or the consent of anyone authorized to speak for him, it is the duty of the physician or surgeon to operate if such action is necessary to save the person's life or preserve his health. In *Moss v. Rishworth*, 222 S.W. 225, a decision of the Texas Court of Appeal, the principle is very clearly set forth as follows:

"The authorities are unanimous in holding that a surgeon is liable for operating on a patient unless he obtains the consent of that patient, if competent to give such consent, or if not, of some one who under the circumstances would be legally authorized to give the requisite consent. If a person should be injured to the extent that he is unconscious and his injuries of such nature as to require prompt surgical attention, a physician called would be justified in applying such treatment as might be reasonably necessary for the preservation of his life or limb, and consent on the part of the injured person would be implied upon the ground of an existing emergency."

This rule is sometimes extended to include the expansion of an operation to which a patient has consented if, during the course of the operation, the surgeon discovers the presence of some other condition which requires immediate attention if the life of the patient is to be prolonged.

If the long-anticipated attack by the enemy upon the coast of California should occur, California physicians would undoubtedly be presented with a great number of cases where they would be required to determine whether the condition of a person injured by a bomb explosion, fire, etc., was such as to require immediate surgical treatment, and whether it would be safe from a legal standpoint to proceed with the treatment without waiting to obtain the consent of the person himself, should he be unconscious, or the parents or guardian, if the injured person should be a child. Whether a person's life or limb is actually endangered may be a difficult question of fact, and many times the physician would be compelled to ignore the possibility of subjecting himself to suit, if his experience and training indicated that immediate surgical treatment was necessary to save the life of the bombing victim.

It is the opinion of this writer that the general rules with respect to operations without consent

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

as set forth above would be applied in substantially the same manner during the war time emergency as during an analogous situation arising in times of peace. There is a complete lack of authority upon this subject, but it would seem that the war should have no legal effect upon the conduct of physicians or surgeons in times of emergency. Possibly, the intense strain under which a physician would be compelled to work during such times might incline the courts to be more lenient in case a court action was subsequently commenced against a physician by a bombing victim operated upon without his consent; but it can be said safely that the physician or surgeon in such times should conduct himself in substantially the same manner as he does when confronted with some serious accident, such as a train wreck or automobile collision. If the condition of the injured person is not such as to require immediate medical or surgical treatment, the physician should delay any surgery or other treatment until the consent of the proper persons can be obtained, but if immediate treatment is necessary to save life or limb, it would be his duty to administer such treatment.

HOSPITAL SURVEY

(Continued from Adv. Page 37)

There were 1,404,940 live births in hospitals during 1941, an increase of 190,448 over the previous year, which is by far the greatest increase recorded in this respect between any two consecutive years. There are nine states in which the number of births in hospitals exceeded 50,000, headed naturally by New York, which reported 180,037 births, followed by Pennsylvania with 112,392, Illinois with 99,997, California with 85,763, Ohio with 82,677, Michigan with 69,670, New Jersey with 60,761, Texas with 59,564 and Massachusetts with 57,642.

For the first time the census obtained data regarding the number of patients operated on in hospitals. During 1941, 5,201,650 patients or 44.86 per cent of those admitted to hospitals were operated on. The report points out that as would be expected the states of New York, Pennsylvania, Illinois, California, Ohio and Michigan, respectively, reported the highest number.

The report explains that the facilities omitted from the list of registered hospitals are of two types: first, those that follow methods and practices such as are generally recognized as unethical or dangerous and that therefore need complete change of policy before being recommended to the public. Their number at the present time is 542. Their capacity, according to the latest available information is 16,267 beds, or less than two thirds of 1 per cent of the facilities furnished by the hospitals recognized in the Register. A second class of facilities not appearing in the Register includes emergency stations, clinics, offices and so on, with some facilities for bed care attached or available. They are recognized as ethical and valuable auxiliary facilities to the hospital system. The bed capacity of these institutions, usually spoken of as unclassified, is too variable to be positively enumerated.

"In January, 1942," the report says, "a survey was made of the facilities for blood and plasma banks in the hospitals approved for internships, residencies and fellowships. Of the 1,070 approved hospitals 462, or 43.2 per cent, reported that such facilities were either in operation or in the process of being established. Some of these institutions also act as manufacturing and distributing centers to supply blood, plasma or serum to other hospitals in the vicinity. The reports also indicated that

many hospitals have commercial products on hand to meet emergency needs."

It was found that 206 hospitals maintain both blood and plasma banks, with 17 others in the process of development. In addition there are 171 hospitals operating plasma banks and 33 separate institutions with blood banks. It was reported that nine additional blood banks are being established as well as twenty-six plasma banks.

The report says that the data serve "to emphasize the fact that hospital facilities must be provided not according to any abstract formula but in accordance with the requirements of the people in the community under consideration."

Report on Toxicity of Mapharsen.—A review of scientific literature since 1935 shows that mapharsen is less toxic than neoarsphenamine in the treatment of syphilis, Edward A. Levin, M. D., and Frances Keddle, M. D., San Francisco, report in *The Journal of the American Medical Association*.

"To date," the two physicians say, "only six fatalities from mapharsen have been reported. This rate is remarkably low considering that over twelve million ampules of mapharsen have been manufactured. The deaths were reported as due to kidney damage in 2 cases, hemorrhagic encephalitis in 1, aplastic anemia in 2, and agranulocytosis in 1. . . .

"About 90 per cent of the patients who have severe gastrointestinal reactions to the arsphenamines can tolerate mapharsen in therapeutic doses. . . .

"The United States Navy statistics on observations of reactions to neoarsphenamine and to mapharsen among patients comparable as to age, sex and general condition of health, indicate that mapharsen is definitely the less toxic."

MEDICAL EPONYM

Little's Disease

William John Little (1810-1894) wrote "On the Influence of Abnormal Parturition, Difficult Labours, Premature Birth and Asphyxia Neonatorum on the Mental and Physical Condition of the Child, Especially in Relation to Deformities" in the *Transactions of the Obstetrical Society of London* (3:293-344, 1862).

"Asphyxia neonatorum, through resulting injury to nervous centres, is the cause of the commonest contractions which originate at the moment of birth, namely, more or less general spastic rigidity, and sometimes of paralytic contraction.

"The former class of affections may be described as impairment of volition, with tonic rigidity and ultimately structural shortening, in varying degrees, of a few of many of the muscles of the body. Both lower extremities are more or less generally involved. . . . Sometimes the affection of one limb only is observed by the parent, but examination usually shows a smaller degree of affection in the limb supposed to be sound. The contraction in the hips, knees, and ankles, is often considerable. The flexors and adductors of thighs, the flexors of knees, and the gastrocnemii, preponderate. In most cases, after a time, owing to structural shortening of the muscles and of the articular surfaces, the thighs cannot be completely abducted or extended, the knees cannot be straightened, nor can the heels be properly applied to the ground. The upper extremities are sometimes held down by preponderating action of pectorals, teres major and teres minor, and latissimus dorsi; the elbows are semi-flexed, the wrists partially flexed, pronated, and the fingers incapable of perfect voluntary direction."—R. W. B., in *New England Journal of Medicine*.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 7, July, 1917

EXCERPTS FROM EDITORIAL NOTES

Druggists' Commissions.—There have already developed interesting features as a result of our editorial, "There Be Land Rats and Water Rats," attacking, in the last issue, the exchange of commissions between the physician and the bandagist. We have been assured by certain druggists that the giving of commissions to physicians, in return for prescription business, is greatly on the wane, but still exists, and that the druggists see no way out. They are ashamed of this phase of their business and would like to see it abolished, but evidently they are so poorly organized that they cannot hang together and put through a reform of this sort. But the druggists are not the only culprits. There are, and we say it regretfully, those among our own ranks who not only accept commissions, but insist upon them. . . .

On the heels of this statement, one pharmacy has done that very thing. It has a printed circular which it has mailed to many physicians, and which will be wrapped with each package, so that the patient may know what is going on. This circular reads, "Our institution is entirely individual and has no financial or pecuniary connection with any physician. If the doctor directs you to have your prescription work done by us, he does it solely for the reason that he knows we can be absolutely depended upon to dispense exactly what he orders. . . . All of which proves that he has your interest at heart."

That is the milk in the coconut.

Read This—It Is For Your Benefit!—You have had it drummed into you until you are sick of it, that to help the JOURNAL you must patronize its advertisers. Now we are asking your help to get advertisements. . . .

Our Legal Records and the Indemnity Defense Fund.—The practice of medicine depends perhaps more than any other branch of scientific endeavor upon experiment and inductive reasoning. And yet it is very difficult to direct the attention of men of this type of mind to matters of intense personal interest to them. We refer to the records of our Legal Department.

These records of claim after claim, and case after case against physicians, should engage the careful consideration of every member. They show conclusively, first, that neglect, carelessness, and lack of skill are not charged only against the younger men, the more inexperienced men, and the men who might not be termed the most learned or careful in any given line of work. But, on the contrary, these records demonstrate that these claims are made and suits are brought with the greatest impartiality against the most experienced, the most skillful, and the most careful of those of whom the profession can boast.

Secondly, these files show that rapacity and ignorance refuse to recognize that man is mortal; that there are few specific remedies; in a word, that a physician is not a warrantor of cures, nor a guarantor of diagnosis and treatment.

(Continued in Front Advertising Section, Page 18)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.

Secretary-Treasurer

Board Proceedings

At the special meeting of the Board held in San Francisco, April 19, 1942, Fred R. DeLappe, M.D., of Modesto, was elected President, and Percival Dolman, M.D., of San Francisco, was elected Vice-President.

News

"Judge James William Morgan yesterday fined T. H. Lee, 627 Main Street, \$100 for violation of the medical practice act, and sentenced him to six months in the county jail, later suspended on condition he refrain from practicing medicine. He was arrested April 14, following an alleged attempted axe attack upon a woman and her husband, who had demanded the return of \$40.00 which they had paid for ineffective medicine." (*Chico Record*, May 7, 1942.)

"Charges against Dr. Roy L. Buffum, prominent Long Beach physician, of performing an illegal operation, were recommended dismissed by the prosecution yesterday after the doctor's two codefendants had pleaded guilty to a similar charge before Superior Judge A. A. Scott. Pleading guilty were Dr. J. J. Tobinsky, whose license has been revoked, and his office manager, J. C. Martin. They applied for probation and their hearing was set for June 16. Dr. Tobinsky and Martin were arrested last Jan. 16. Dr. Buffum was taken into custody at the same time and accused of having sent women patients to Tobinsky. Deputy District Attorney John Hopkins, however, told the court that there is not sufficient evidence to warrant trial of Dr. Buffum." (*Los Angeles Herald and Express*, May 19, 1942.)

"Have a yen, now and then, for a letter? Does the postman pass you by? There's a simple solution. Just apply for a marriage license. You'll get lots of mail. . . . Of first importance is compliance with California's medical examination law. Blood tests and health certificates are available from \$1.40 per person up, you learn in bold, black type, and every laboratory guarantees hurry-up, 24-hour service. . . ." (*Santa Monica Outlook*, May 13, 1942.)

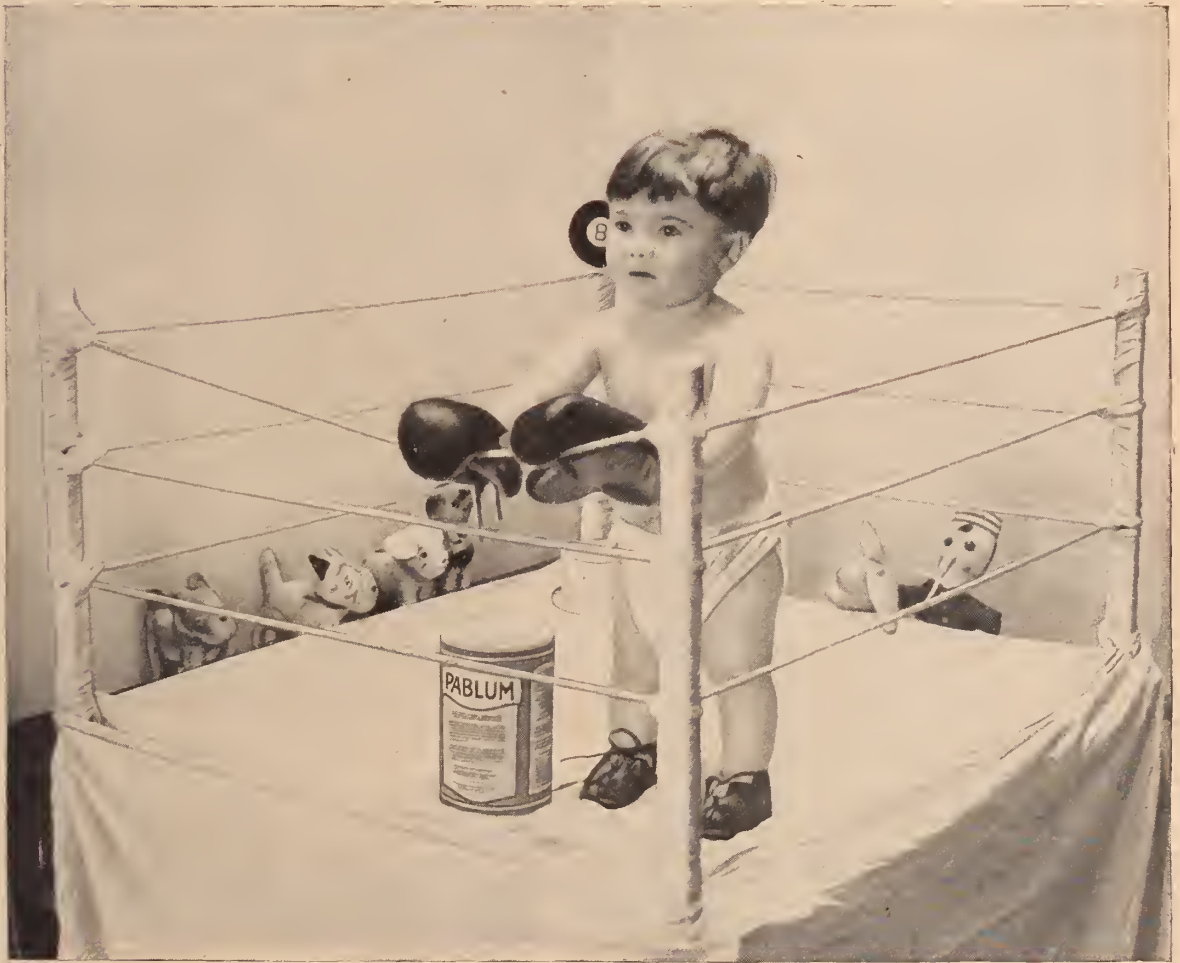
"Charged with having engineered abortions for unmarried women, Mrs. Carmen Cantu, 40, of 1219 West Second St., Santa Ana, was jailed by District Attorney George F. Holden's investigators and Santa Ana police late yesterday. . . ." (*Orange News*, May 13, 1942.)

"Physicians living permanently in California, but not licensed in this state, may not use social calling cards carrying the designation 'Doctor' or 'M.D.', Attorney General Earl Warren has advised the State Board of Medical Examiners. Warren's opinion said that for many physicians the calling card is the only means of holding

(Continued in Back Advertising Section, Page 31)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.



THE FITTED DIAPHRAGM WITH JELLY

THE TUBE METHOD



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130 STORES ON THE PACIFIC COAST

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 20)

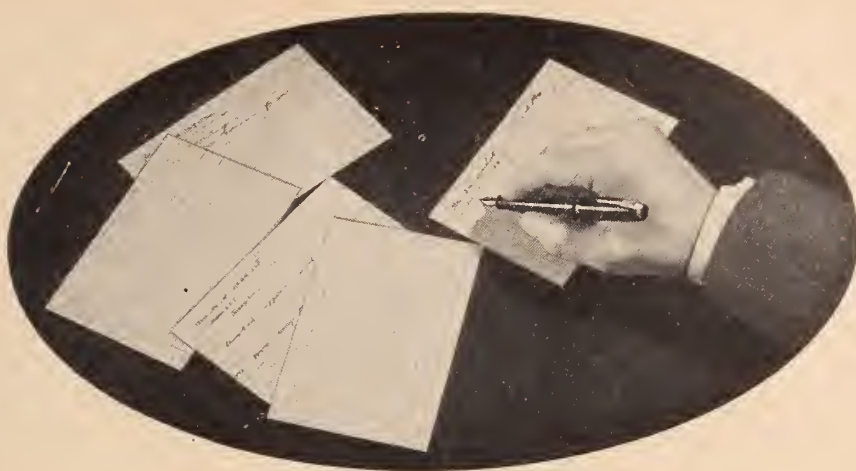
From an Article on "Tumors of the Kidney," by H. C. Moffitt, M. D., San Francisco.—Three questions are not infrequently raised by the history or examination of a patient:

1. Do certain symptoms suggest a kidney tumor, and of what weight are they in the diagnosis?
2. Is an abdominal mass a tumor of the kidney, or of some other organ?
3. Do certain general or distant signs point to a kidney tumor, or do they help decide the nature of a questionable abdominal mass?

From an Article on "Modern Diagnosis and Treatment of Nephrolithiasis," by Wm. E. Stevens, M. D., San Francisco.—The advance in urology during the past decade, due principally to an enlarged and improved diagnostic armamentarium, has so increased our facilities for examination that the detection of urinary calculi is comparatively simple in the majority of cases. In a not inconsiderable number, however, the characteristic objective and subjective symptoms are absent or confusing, and the findings negative or misleading. It is these cases that sometimes tax to the utmost our diagnostic resources. Notwithstanding these difficulties, the number of patients operated upon, following the erroneous diagnosis of nephrolithiasis, is still too large to be of credit to modern genito-urinary surgeons. The principal reason for these mistakes may be expressed in three words—insufficient preliminary investigation. . . .

(Continued on Page 26)

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smoke itself! In the same tests, Camel burned slower than any of the 4 other largest-selling brands tested.* * *

*J.A.M.A., 93:1110—October 12, 1929

Brückner, H.—*Die Biochemie des Tabaks*, 1936

***The Military Surgeon*, Vol. 89, No. 1, p. 5, July, 1941

****ibid.* p. 5

- SEND FOR REPRINT of an important contribution to medical literature—"The Cigarette, The Soldier, and The Physician," *The Military Surgeon*, July, 1941—revealing many new angles about smoking. Write Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.

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Hydrotherapy Combined With a Warm Dry Climate

For particulars write

LEE RICHARDSON, RICHARDSON SPRINGS, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Page 24)

From an Article on "Mercurialized Serum Injections in Syphilitic Nervous Diseases," by H. G. Mehrrens, M.D., San Francisco.—The intradural treatment of syphilis of the nervous system has received a constantly increasing amount of attention since the publication of the results of Swift and Ellis. Even before the efficacy of that method could be finally settled, the scarcity of salvarsan made its use almost prohibitive. Therefore, in July, 1915, in the Neurological Clinic of the Stanford Medical School, we began to treat a series of cases using the Byrnes method of mercurialized serum injections. The following is a preliminary report of that work (thirty cases—190 injections). . . .

From an Article on "The Economic Importance of the


Well-Poised Person," by Harry Leslie Langnecker, M.D., San Francisco.—The purpose of this paper is to emphasize the importance of the correction of the mechanics of the human body in the treatment of disease. In most of the cases, especially those of a chronic nature, which come to the general practitioner, and more often to the orthopedic surgeon, either directly or indirectly, the anatomy or physiology is faulty.

From an Article on "Fractures in War Time," by Leo Elocsser, M.D., San Francisco.—In complying with the kind invitation of Dr. L. L. Stanley to talk to you on some topic from military surgery, I have chosen the subject of fractures as being one of more general interest.

The material of a military hospital is, thank God, very different to that seen in a civil practice. The fractures

(Continued on Page 28)

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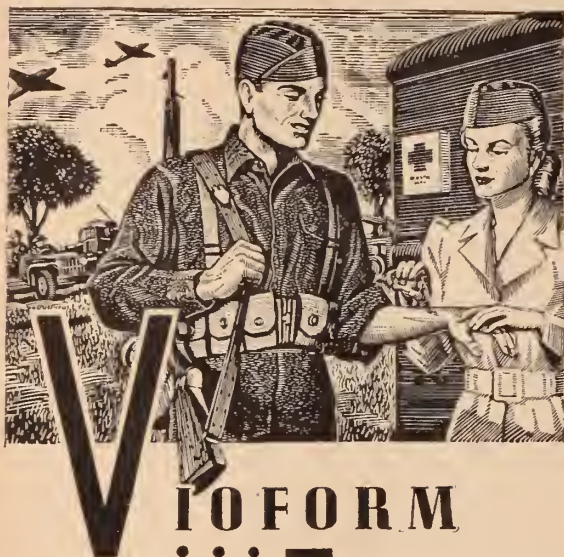


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Accredited by the American Medical Association and Approved by the American College of Surgeons. Open to all members of the California Medical Association. Accredited School of Nursing and Out-Patient Department.

TWENTY-FIVE YEARS AGO

(Continued from Page 26)

are much more severe than those that we meet in our daily work. Still the treatment of compound fractures remains the same in peace or war, and I think that experience gained among the wounded may be of some interest and value in civil life.

The great mass of fractures seen in military practice are compound—there are simple fractures, too, of course. Men fall down in the trenches, or are run over or struck by heavy objects in the field as well as at home. These, however, I shall not consider tonight.

From an Article on "Leukopenia, its Significance," from the Department of Clinical Medicine of the San Francisco Polyclinic. By Joseph H. Catton, M.D., San Francisco.—Leukocytosis is one of the most valuable aids in diagnosis. While the presence of a leukopenia has been made use of in the diagnosis of malaria, typhoid, influenza and Banti's disease; and its appearance has been regarded as ominous when it has replaced an expected leukocytosis, as in pneumonia—nevertheless its full significance has been unappreciated. Standard texts on diagnosis and many works on hematology dismiss leukopenia with a paragraph, and often it is simply referred to as the absence of leukocytosis. Ehrlich has said, "a reduction in the number of white cells plays a very unimportant rôle in comparison to their increase."

From an Article on "Subdeltoid Bursitis," by Saxton Temple Pope, M.D., San Francisco.—Subdeltoid bursitis has been called many names: peri-arthritis, brachial neu-

(Continued on Page 30)

G-E X-RAY SERVICE

SPANS THE COUNTRY—

IT might surprise you to know that an x-ray unit . . . such as the KX-8-33 with centralinear control...contains nearly 12,000 parts.

These parts are so durable and well-fitted in any General Electric unit that most of them function for the life of the equipment with but little attention. However, since anything mechanical requires some care, G-E accepts the responsibility to provide service based on complete knowledge of the whole unit.

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PARK SANITARIUM 1500 PAGE ST.
SAN FRANCISCO.

TWENTY-FIVE YEARS AGO

(Continued from Page 28)

ritis, circumflex neuritis, and rheumatism; but Codman first gave an accurate description of the disease and dictated its cure.

From Society Notes:—Mendocino County. To All Industrial Accident Insurance Companies:
Gentlemen:

The following resolution was adopted by the House of Delegates at the recent meeting of the Medical Society of the State of California, held at Coronado, California, April 17, 1917:

"WHEREAS, Certain Insurance Companies have employed physicians on a salary basis, to care for as much of their surgical work as possible, at a price inadequate to cover reasonable fees for labor performed; and

"WHEREAS, It was the distinct understanding between the Industrial Accident Commission, the State Fund and the Adjusters' Association and the Medical Society of the State of California, that such practice would not be adopted; be it

"Resolved, That the Industrial Accident Commission, the State Compensation Fund and the Adjusters' Association be reminded of this agreement, and requested to desist from this practice, and that such members participating in such a contract be disciplined by their County Society, and that the names of the Insurance Companies, which are parties to such a contract, be made known to the members of this Society by its officers. It was further

"Resolved, That the Secretary of the Mendocino County Society be instructed to send a copy of this resolution to all Industrial Insurance Companies."

OSWALD H. BECKMAN, *Secretary.*

From "The State Board of Health May Meeting."—The State Board of Health held its regular monthly

meeting in Sacramento, on May 5, 1917. The following members were present: Drs. George E. Ebright, president; Fred F. Gundrum, Edward F. Glaser, Adelaide Brown and Robert A. Peers. . . .

The following resolution was adopted and ordered sent to the mayors of all incorporated cities in California:

"WHEREAS, Every possible protection to health and physical welfare should be afforded those enlisting in the Federal service and the citizens of the state at large; and

"WHEREAS, Experience shows that, unless restrained by public authority, prostitutes gather in large numbers near army camps and spread venereal diseases among the soldiers; and

"WHEREAS, Said diseases are a serious factor in morbidity and reduced efficiency, and a menace to the public health; therefore, be it

"Resolved, That the State Board of Health of California urge upon all mayors throughout the state that they demand from their health officers, police departments, and other appropriate officials an active policy of protection of the enlisted men and of the civil community against this menace to the public health; and, be it further

"Resolved, That detailed reports be requested of said officials setting forth the recommendations made by them and the methods of 'preparedness' being enforced by them to meet this public health problem." . . .

Outlook for Mumps Control Improved.—An outbreak of mumps in a military establishment may lead to serious consequences in the way of days lost through hospitalization, Conrad Wessellhoeft, M. D., late Captain Medical Corps, United States Army, Boston, and Charles F. Walcott, M. D., Major, Medical Corps Reserve, United States Army, Cambridge, Mass., declare in the current issue of *War Medicine*, published bimonthly by the American Medical Association in coöperation with the Division of Medical Sciences of the National Research Council.

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EVAPORATED MILK

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Largely because of your widespread recommendation of SPECIAL MORNING MILK, we have expanded our business, with a new plant at Sunnyside, Washington.

Here, as at our model Utah and California plants, we are producing evaporated milk of uniformly high quality.

We appreciate your confidence in our product and hope to merit your support in the future.

MORNING MILK COMPANY

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 58)

out' they are in practice, and that for unlicensed doctors to use cards indicating their profession thus would be, in a sense, a misrepresentation and a violation of the code." (San Diego Tribune, May 14, 1942.)

"Led to his downfall by a prescription which he irregularly signed, Arthur Osborne Phillips, 47, alias Dr. James Herman Phillips, part-time house doctor at the Enloe Hospital, was held under \$1000 cash bail in the city jail today, awaiting hearing on charges of practicing medicine without a license and as an ex-convict, carrying concealed weapons. Phillips, who confessed to Joseph W. Williams, special agent for the State Board of Medical Examiners, to having served terms in eight prisons on charges ranging from defrauding hotels, practicing medicine without a license and impersonating a federal officer, was booked at the city jail shortly after 6 o'clock last night on charges of practicing medicine without a license and carrying concealed weapons. Without ever having studied medicine in his life, Phillips, according to his confession, had performed operations and prescribed medicine to patients over a period of 14 years. He was employed at the hospital two months ago after he had presented to Dr. N. T. Enloe a letter on government stationery and purported to be signed by a government official, in which he was given permission to leave the Brush Creek CCC camp, where he was a government physician, and enter the employ of the hospital for part-time, hospital authorities said. . . . Williams interviewed Dr. Phillips at the Enloe Hospital and was convinced

that a thorough investigation was in order. . . . The following investigation disclosed that Phillips had served terms in eight jails and penitentiaries. . . . Confronted with his prison record, as obtained by Williams, Phillips admitted its correctness and withdrew the statements he had previously made regarding his successful medical career. . . . In a 14-page confession by Phillips, dictated to a stenographer at the Enloe Hospital yesterday afternoon, Phillips made a clean breast of his long career as a fake doctor and his terms in prison. . . . Williams said that since Phillips was released from the Idaho penitentiary, where he was sent for practicing medicine in Boise, Idaho, he established himself at Gerber, Montana, as an eye, ear, nose and throat specialist. . . . The Investigator said Phillips got a \$3,500 a year job with the CCC camp at Brush Creek. . . . He left the CCC camp two months ago to go to work as part-time house doctor for Dr. N. T. Enloe, operator of the Enloe Hospital in Chico, at \$250 a month, with the privilege of engaging in private practice on the side. . . . During his career as a doctor, Arthur Osborne Phillips had gone under the following names: Arthur Osborne, Dr. A. O. Phillips, A. O. Phillips, Dr. Arthur Phillips, Dr. James Herman Phillips, James Herman Phillips and Arthur O. Phillips. The real Dr. James H. Phillips is confined in a Veterans' Hospital in Georgia from injuries received in the world war. The impersonator learned that Dr. Phillips' condition is such that he never again will be able to leave the hospital. Acting on this information, the prisoner wrote the University of Tennessee from which Dr. Phillips graduated and asked for a certified copy of his diploma, stating that he had lost the original during the world war. He received the diploma. . . ." (Chico Enterprise, May 27, 1942.)

(Continued on Page 32)

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WAR BABY—

YOUR BUREAU was born in 1916. Some of you Doctors will remember your problems then for that was during **WORLD WAR ONE**. It (**Your Bureau**) was organized then to help Doctors and it has been helping them ever since. And now much more than ever, tell it your troubles.

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Garden Grove Sanitarium

General and Neuro-Psychiatric

GARDEN GROVE

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Richard A. Carter, M.D.

Resident Neuro-Psychiatrist

BOARD OF MEDICAL EXAMINERS

(Continued from Page 31)

"His bail raised from \$5,000 to \$25,000 as the result of charges that he has been 'tampering' with witnesses who accuse him, Dr. James Petric, chiropractor, illegal operation-murder suspect, was lodged in jail again yesterday. . . ." (Los Angeles Examiner, May 19, 1942.)

"Dr. C. C. Gans, county health director, today received formal notification from the U. S. Public Health Service that it will be his duty to establish a public health program for the assembly center at Tanforan Race Track, San Bruno, where it is expected between 8,000 and 10,000 alien and citizen Japanese will be congregated. . . ." (Redwood City Tribune, April 28, 1942.)

"Dr. Walter R. Amlin, 46-year-old chiropractor, who was convicted of second degree murder and abortion in the death of Mrs. Louistine O. Bowers, 22, Negro, yesterday was serving a nine months county jail sentence, imposed by Superior Judge Frank C. Collier. The sentence, which carried a road camp recommendation, was meted out by the judge to the dark, dapper doctor in lieu of a state prison term. In suspending the prison term, the judge ordered Dr. Amlin to serve nine months in the county jail, surrender his license and give up his practice as a chiropractor and pay all funeral and other expenses incurred by Mrs. Bowers' husband. . . . Charges against Dr. Amlin were the outgrowth of an illegal operation he performed on Mrs. Bowers last September 6, in his offices at 30 North Raymond Avenue." (Pasadena Independent, April 29, 1942.)

"A resolution calling for revocation of license to practice of all medical men found guilty of subversive activity was adopted by the California Medical Association at the final session of its 71st annual convention. The House of Delegates voted to confer with the Board of Medical Examiners regarding introduction of legislation for this purpose at the next session of the State Legislature. . . ." (Oakland Tribune, May 7, 1942.)

"Dr. A. M. Tweedie, maintaining offices at 3326 W. 54th St., was held in University Jail today in connection with the death yesterday of Mrs. Leona Tarleton, 35, of Santa Monica. According to police, Mrs. Tarleton died in Dr. Tweedie's office as he was about to administer an anesthetic for an examination. . . ." (Hollywood Citizen-News, June 2, 1942.) (Previous entries, Dec., 1936; July, Aug. and Dec., 1937.)

(Continued on Page 34)

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with a little time to himself!

You're right! Something should be done these days to give physicians more time for themselves . . . and S-M-A* infant feeding formula is helping to do it!

Take the case of the physician whose patients kept calling up to discuss "Formula Troubles." He decided to save time by prescribing S-M-A for normal infants deprived of breast milk. Don't take our word for it—in a recent survey among 3935 physicians who fed S-M-A, 76% of those reporting said S-M-A saved time; 89% of those reporting said S-M-A was easier for mothers to prepare; 85% of those reporting said with S-M-A they observed freedom from digestive upsets.



*S-M-A, a trade mark of S. M. A. Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

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The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
2. Education as to essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
4. Every proved method of treatment, including pneumothorax and phrenic nerve interruption. (Major thoracic surgery referred to skilled thoracic surgeons.)
5. An absence of institutional atmosphere.
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to the profession in the Armed Forces at a
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**THE
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FORT WAYNE, INDIANA

BOARD OF MEDICAL EXAMINERS

(Continued from Page 32)

"Superior Judge Kenneth E. Morrison today upheld the conviction of Dr. A. M. Lovaas of Santa Ana, a chiropractor, who currently is secretary of the grand jury, who appealed from a Santa Ana justice court decision holding him guilty of violation of the state medical practices act. Dr. Lovaas was tried before a jury in Justice Howard Cameron's court and fined \$250 on November 28, 1941, after he was found guilty of two of three counts brought against him. His appeal has been pending since. . . . Basis for the prosecution of Dr. Lovaas was an alleged treatment of E. W. Leuenberger, to whose tonsils Dr. Lovaas allegedly applied an electrode. Judge Morrison held that ' . . . electrical treatments constitute the practice of medicine and surgery.' He went on to explain that California law provides that chiropractic deals with placement of vertebrae for relief of pressure on the nerves. Principal ground for appeal by Dr. Lovaas was that electrode treatment of this nature was taught in the chiropractic school he attended. There was no contest on the point that the electrode treatment was applied, Dr. Lovaas contending his right to practice such a system." (Orange News, May 26, 1942.)

"Dr. John P. Mason, chiropractor, 180 West Highland Avenue, was found not guilty by a jury in Justice H. O. Harrawood's court yesterday on a charge of having violated a section of the state business men's and professional code. . . . State investigators charged Dr. Mason with practicing medicine and surgery without a license in treating a throat case with an electrical machine. . . ." (Redland Facts, May 27, 1942.)

(Continued on Page 36)

“Soup Kitchen” for Bacteria

BACTERIA AND THEIR FELLOW TRAVELERS, the viruses, are epicures of the first order. Deny them the right ration and they refuse to go on living in the laboratory. Some subsist on daily dishes of milk and potatoes, while others thrive on beef tea and special mixtures of agar, gelatin and animal juices. The pneumococcus, a finicky fellow, must be fed the heart of the beef for the greatest proliferation. And we could go on citing many more cases of how science has satisfied their appetites.

A quarter of a million pounds of meat were consumed by bacteria at Lederle last year. Add to this a yearly consumption of two and a half million liters of agar solution, not to mention volumes and volumes of other culture media, and you have, we believe, the world's largest “soup kitchen” for bacteria. Here they are cultured under scientific control, allowed to thrive and then put to use for man's benefit.

Propagation of micro-organisms and viruses is a major feature of the art of biological production. At Lederle this important phase is under the direction of a staff of skilled bacteriologists, long experienced in making superior serums, anti-toxins, vaccines and toxoids for the prevention and treatment of diseases of man and animals.

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Each patient receives individual study and care. The referring physician re-

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Climate is ideal. Located at 1,000 ft. elevation, 6 miles east of San Jose, overlooking the Santa Clara Valley. A folder will be sent on request.

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And Operating THE MEDICAL OFFICE BUILDINGS, Facing the Hospital
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BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

A report from Special Agent Anderson relates that Dr. Morris, D. C., Secretary of the Board of Chiropractic Examiners, testifying in behalf of Chiropractor Mason, made a statement that "he has been using electro-coagulation in his practice of chiropractic for at least sixteen years, and that he has removed at least 200 pairs of tonsils by electro-coagulation, and that he had instructed licensed chiropractors in the State of California that they could legally use electro-coagulation."

HOSPITAL SURVEY

(Continued from Advertising Page 21)

ment since the publication of the last previous issue of the Hospital Number of *The Journal* on March 15, 1941. However, the statistical data include those on all registered hospital facilities.

"Registration means the inclusion of the hospital in the list published in the Hospital Number of *The Journal* and in the American Medical Directory," the report explains. "The Essentials of a Registered Hospital are employed in such a way as to raise the standards of hospitals and to point the way to better service.

"Approval, on the other hand, means specific endorsement of hospitals for educational purposes, the fitness for which is determined by observation, inspection and comparison with definite requirements for intern training and residencies.

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the Council has no evidence of irregular or unsafe practices. Approval is designation of certain registered institutions by the Council for internships, residencies and fellowships; or by the American College of Surgeons as unconditionally meeting its minimum standards. . . ."

During 1941 federal hospitals admitted 1,268,112 patients, including those of the Veterans Administration, Army, Navy, Public Health Service, the Departments of Justice and of Indian Affairs, the Tennessee Valley Authority and the National Youth Administration. The average census of patients in federal hospitals was 118,890.

The number of state hospitals was 530, an increase of 9 during the year, and the capacity was 600,320 beds as compared with 572,079 beds in 1940. They admitted 620,231 patients and the average daily census was 561,620, an increase of 36,957 admissions and of 21,626 in the average daily census over the previous year.

A total of 512 county hospitals are listed for 1941 as compared with 514 in 1940 and the capacity decreased to 98,227 beds. Bassinets, however, showed a slight increase in number, totaling 3,288. Patients admitted to county hospitals were 643,740 as compared with 615,247 for the preceding year while the average census of patients was 83,214 as compared with 87,029 in the previous year.

City hospitals totaled 337 in number, an increase of 5 over the previous year while the bed capacity increased to 78,060 and bassinets to 5,045. The total number of patients admitted was slightly increased to 999,559 and the average census was reduced from 63,644 in 1940 to 61,019 in 1941.

City-county hospitals were fewer in number, capacity and average census than in 1940, but the number of patients admitted was increased from 126,487 in 1940 to 130,960 in 1941.

(Continued on Page 37)

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HOSPITAL SURVEY

(Continued from Page 36)

Church related hospitals number 993, which is 5 less than the previous year, but the group shows very substantial increases in its facilities. The other nonprofit hospitals increased in number from 1,903 in 1940 to 1,917 in 1941. The census shows a tendency toward increase in the average size of nongovernmental hospitals rather than in number.

The number of general hospital beds by states varies from 2.1 per thousand population in Utah to 8 beds per thousand in Nevada. Other states ranking high in the number of general hospital beds per thousand are: Arizona, 7.4; Wyoming, 6.0; California, 5.9; Massachusetts, 5.9; Washington, 5.8; Colorado, 5.7; Louisiana, 5.7; Florida, 5.1.

It is pointed out that the outstanding fact to be observed is that those states which provide few beds are found to have a low rate of occupancy, and, of course, a small proportion of the population making use of hospitals. For example, Utah, with 2.1 general hospital beds per thousand, shows an occupancy rate of 55.3 per cent, and its general hospitals were used by 3.5 per cent of the state population. Nevada, with 8 beds per thousand, had an occupancy rate of 63.4 per cent; 12.3 per cent of the population of the state made use of its general hospitals during the year. Oregon, the twenty-fourth state or midway point in number of general hospital beds per thousand, shows an occupancy rate of 73 per cent, and 9.9 per cent of its population entered a general hospital. Average figures for the entire country show 4.1 general beds per thousand of population, an average occupancy of 68.2 per cent and 8.1 per cent of the entire population entering general hospitals as patients.

(Continued on Page 113)

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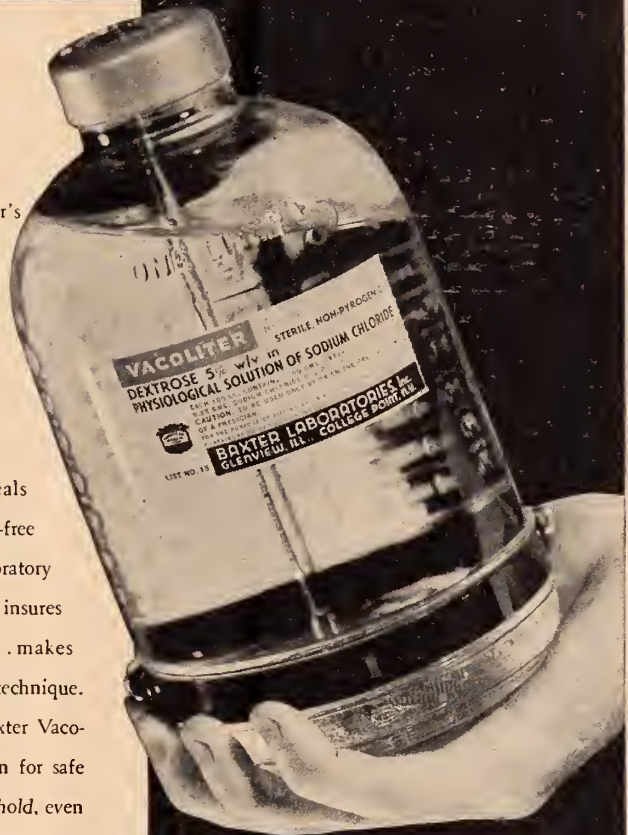
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President, Max J. Goodman, 525 7th Street, Eureka.
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Meeting, *First Thursday.*

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Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

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President, J. Headen Inman, 501 Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
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Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

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Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

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President, Edward A. Macklin, P.O. Box 176, Kelseyville.
Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

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President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

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President, Winton F. Swengel, 499 Pacific Street, Monterey.
Secretary, Raymond V. Rukke, 135 Franklin Street, Monterey.
Meeting, *First Thursday.*

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Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

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Secretary, Hobart M. Kelly, 8616 Main Street, Riverside.
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President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

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Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

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Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

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President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

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2180 Washington Street, San Francisco
President, John W. Cline, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

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Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
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Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
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Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

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Meeting, *Second Monday.*

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Meeting, *Sunday on call.*

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Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
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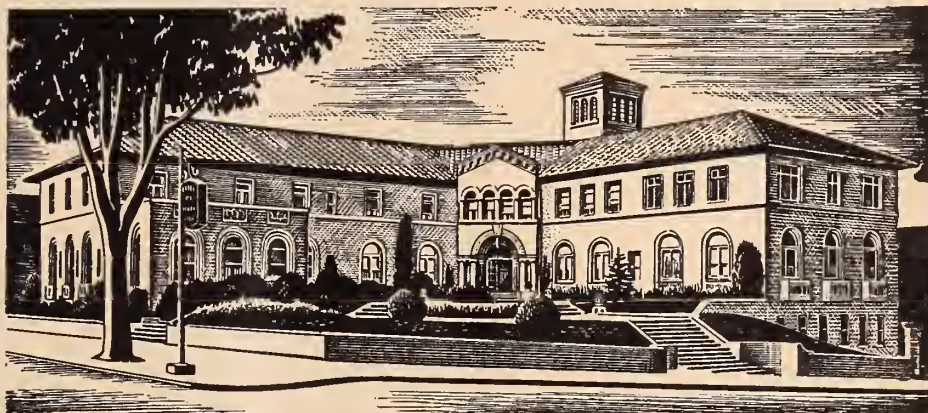
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Psychologic Care During Infancy and Childhood. By Ruth Morris Bakwin, B.A., M.A., M.D., Assistant Clinical Professor of Pediatrics, New York University College of Medicine; Director of Pediatrics, New York Infirmary for Women and Children; Assistant Pediatrician, Bellevue Hospital, New York City; and Harry Bakwin, B.S., M.D., Associate Professor of Pediatrics, New York University College of Medicine; Associate Pediatrician, Bellevue Hospital, New York City; Consultant, Middletown Hospital, Middletown, N. Y. Cloth. Pp. 297. New York: D. Appleton-Century Company, Inc., 1942.

History of the School of Nursing of the Presbyterian Hospital, New York, 1892-1942. By Eleanor Lee, A.B. R.N., Assistant Professor of Nursing, Department of Nursing, College of Physicians and Surgeons, Columbia University, Instructor in History of Nursing, Chairman of the Education Committee of the Alumnae Association of the School of Nursing of the Presbyterian Hospital. Cloth. Price, \$3.50. Pp. 278 with 57 illustrations. New York: G. P. Putnam's Sons, 1942.

Physicians' Reference Book of Emergency Medical Service. A compilation, chiefly from medical literature, presenting the practical experience and lessons acquired in handling civilian war casualties. Paper. Pp. 268. New York: E. R. Squibb & Sons, New York, 1942.

Ambassadors in White. By Charles Morrow Wilson. Illustrated. Cloth. Price, \$3.00. Pp. 372. New York: Henry Holt & Co., 1942.

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(Continued from Page 7)

The Management of Fractures, Dislocations, and Sprains. By John Albert Key, B.S., M.D., St. Louis, Mo., Clinical Professor of Orthopaedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's and Jewish Hospitals; and H. Earle Conwell, M.D., F.A.C.S., Birmingham, Ala., Orthopaedic Surgeon to the Tennessee Coal, Iron and Railroad Company and the Orthopaedic and Traumatic Services of the Employees' Hospital and to the American Cast Iron Pipe Company; Chairman of the Committee on Fractures and Traumatic Surgery of the American Academy of Orthopaedic Surgeons; Member of the Fracture Committee of the American College of Surgeons; Associate Surgical Director of the Crippled Children's Hospital; Attending Orthopaedic Surgeon to St. Vincent's Hospital, South Highlands Hospital, Hillman Hospital, Children's Hospital, Baptist Hospitals and Jefferson Hospital, Birmingham, Alabama. Third Edition. Cloth. Price, \$12.50. Pp. 1303 with illustrations. St. Louis: The C. V. Mosby Company, 1942.

The National Formulary. Prepared by the Committee on National Formulary by Authority of the American Pharmaceutical Association. Official from November 1, 1942. VII Edition. Pp. 690. Published by the American Pharmaceutical Association, Washington, D. C., 1942.

The Reception of William Beaumont's Discovery in Europe. By Dr. George Rosen, with a Foreword by Dr. John F. Fulton. Cloth. Price, \$5.00. Pp. 97. New York: Schuman's.

The Surgery of Pancreatic Tumors. By Alexander Brunswick, M.S., M.D., F.A.C.S., Professor of Surgery, University of Chicago. Cloth. Price, \$7.50. Pp. 421, with 123 text illustrations by Gladys McHugh and one color plate. St. Louis: The C. V. Mosby Company, 1942.

(Continued on Page 14)

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154—*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60 *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241—*N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592

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(Continued from Page 10)

Sex Fulfillment in Marriage. By Ernest R. Groves, Professor of Sociology, University of North Carolina, Gladys Hoagland Groves, author of "Marriage and Family Life," and Catherine Groves, author of "Get More Out of Life." Introduction by Robert A. Ross, M.D., F.A.C.S., Associate Professor of Obstetrics and Gynecology, Duke University, School of Medicine, Member of the American Gynecological Society, American Association of Obstetricians, Gynecologists and Abdominal Surgeons, etc. Illustrations by Robert L. Dickinson, M.D. Cloth. Price, \$3.00. Pp. 319 with illustrations. New York: Emerson Books, Inc., 1942.

Essentials of Pathology. By Lawrence W. Smith, M.D., Professor of Pathology, Temple University School of Medicine; formerly Assistant Professor of Pathology, Harvard Medical College, and Associate Professor of Pathology, Cornell University Medical School, and Edwin

S. Gault, M.D., Associate Professor of Pathology, Temple University School of Medicine, with a Foreword by James Ewing, M.D., Memorial Hospital, New York City. Second edition. D. Appleton-Century Company, Inc., New York-London, 1942.

BOOK REVIEWS

Textbook of Clinical Parasitology. By David L. Belding, M.D., Professor of Bacteriology and Experimental Pathology, Boston University School of Medicine; Member of Staff of Evans Memorial and Massachusetts Memorial Hospitals. Cloth. Price, \$8.50. Pp. 890, with 1356 illustrations on 279 figures, and 82 illustrations on 4 full page color plates. New York: D. Appleton-Century, Inc., 1942.

The title of this book might be construed to infer a field of usefulness to the average practitioner of medicine. It is, however, essentially an encyclopaedia of human parasitism, of global scope, and abounds in Latin names incident to accurate biological classification. The most helpful section for medical practitioners might easily prove to be the list of medicaments useful in the treatment of parasitic diseases.

The first sentence of Chapter I defines parasitology as "the science which deals with organisms that take up their abode, temporarily or permanently, on or within other living organisms for the purpose of procuring food." It is at least unexpected on this basis to find a later treatment of bee and scorpion stings, and the bite of the black-widow spider, which, if it is for purposes of feeding, would seem to need some argument to establish the point.

As an encyclopaedia this book should find its greatest usefulness as a reference work for those whose activities occasionally touch the problem of medical parasitism but who lay no claim to being deep students of the subject.

HOWARD A. BALL, M. D.

(Continued on Page 17)

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BOOK REVIEWS

(Continued from Page 14)

The Toxemias of Pregnancy. By William J. Dieckmann, M. D., Associate Professor of Obstetrics and Gynecology, The University of Chicago; Attending Obstetrician, The Chicago Lying-in Hospital and Dispensary; Attending Gynecologist, Albert Merrit Billings Memorial Hospital of the University of Chicago; Associate Editor of the American Journal of Obstetrics and Gynecology; Co-chairman of the Conference of Eclampsia, United States Department of Labor, Children's Bureau, 1941. Cloth. Price, \$7.50. Pp. 521, with 50 illustrations and 3 color plates. St. Louis: The C. V. Mosby Company, 1941.

This book consists of 32 chapters, divided into sections dealing in turn with: I. Classification, Incidence and Pathology of Toxemias; II. Normal and Abnormal Physiology; III. Etiology of Eclampsia; IV. Clinical Aspects of Toxemias; V. Treatment; VI. Prenatal Care

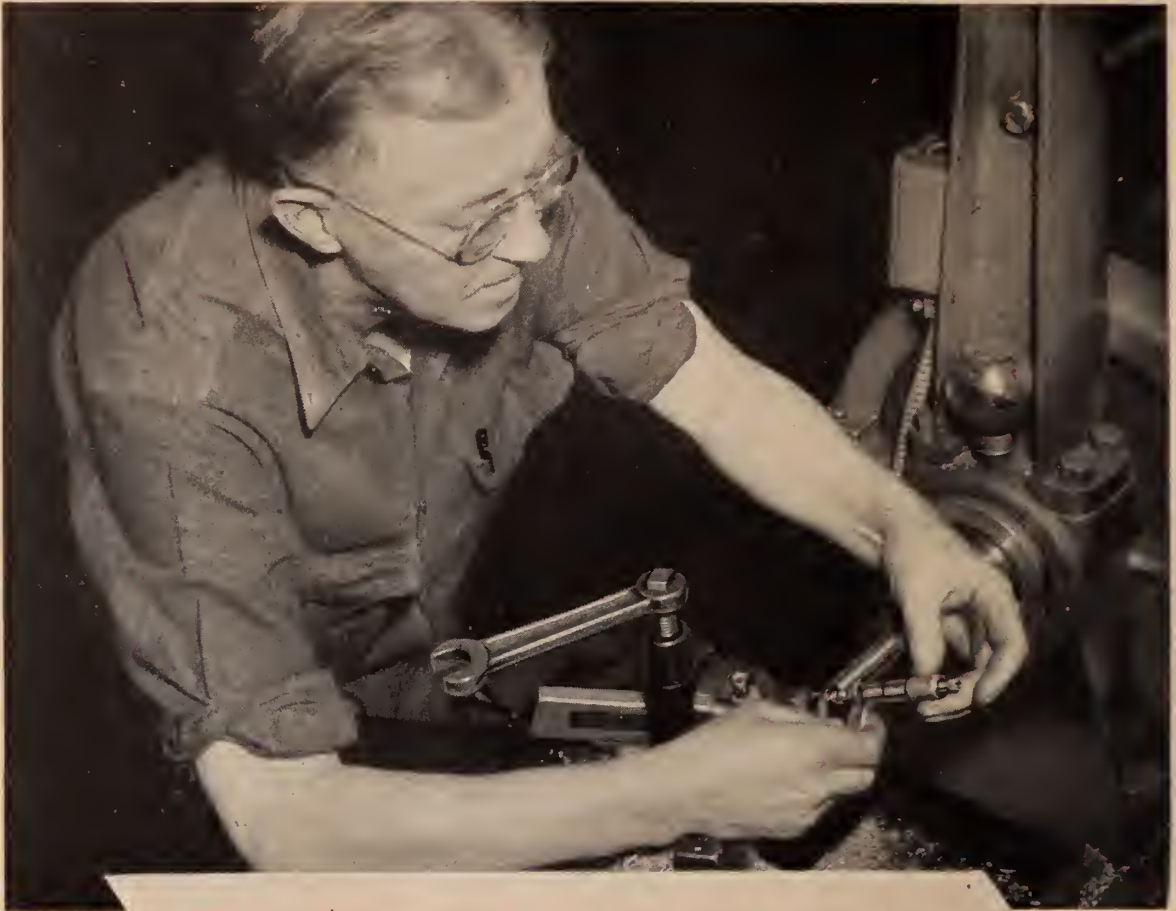
and Prognosis. Illustrations, tables, and graphs are laudible. The author gives summaries of current theories and practices, gathered from the literature of the past 12 years, and his own personal theories and methods. Each chapter is followed by a very complete bibliography.

Much space has been devoted to a detailed discussion of normal and abnormal physiology and chemistry. The prepresent pioneering in a field little explored to date.

The author states that the book was written with two objects in mind: (1) To acquaint the obstetrician with some of the recent contributions on physiology pertaining to obstetrics, (2) To acquaint the investigator, untrained in obstetrics, with some of the physiology and pathology of obstetrics. Both of these objectives are well achieved. This work presents an exhaustive review of present concepts of toxemia compiled and brought

(Continued in Back Advertising Section, Page 20)

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND
WESTERN MEDICINE has prepared a leaflet explaining its rules re-
garding publication. This leaflet gives suggestions on the prepa-
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contributors to this Journal write to its offices requesting a copy
of this leaflet.

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EDITORIALS

CALIFORNIA ELECTIONS: PRIMARY, ON AUGUST 25th; FINAL, ON NOVEMBER 3d. THEIR SIGNIFICANCE TO MEDICINE AND THE PUBLIC HEALTH

War Times do not Obliterate Civic Respon-
sibilities.—Our Country being at war, there
may be some physicians who would contend that
state and local politics should have little or no
place for consideration at this time. Such an
attitude, however, does not make for efficient
service in either war or civilian activities.

Since the placement of responsibilities and
duties upon duly constituted agencies cannot be
permitted to lapse even during periods of peace—
because civilized nations must always carry on
their lives in orderly fashion—it is increasingly
important that under the stress and strain of exist-
ing warfare, careful thought be given concerning
the capacity for service of those upon whom rests
the responsibility for guidance of the State in
these present days of peril.

Service with the armed forces has caused the
withdrawal from civilian practice of many thou-
sands of physicians (the allotment for California
by the end of 1942 being not less than 2600 phy-
sicians in military service!); and it must be evi-
dent to all observers, that, once the war is over,
it will take some years of readjustment to again
bring back the practice of medicine to something
of the form which existed before December 7,
1941. If the war continues for several years, as
present circumstances would indicate, the condi-
tions will be aggravated.

It is of great importance, therefore, that no
laws be enacted that would add to present or
imminent burdens. Or, to put it otherwise, that
the interests of the public health and medical
practice should not be jeopardized through ill-
advised legislation at this time.

* * *

Primary Election on August 25th and Final
Election on November 3d.—This last state-
ment may remind us of our obligations in the two
state elections soon to be held—the Primary Elec-
tion on Tuesday, August 25th, and the final State
Election on Tuesday, November 3d. Every phy-
sician should be fully alert to his civic responsi-
bilities, and particularly acquaint himself with
the names and backgrounds of candidates for the
State Senate and State Assembly. It is the legis-
lators who enact the laws; and the merit of the
statutes which come out of the legislative hopper

at each biennial session at Sacramento bears a direct and somewhat proportionate relationship to the kind of law-makers who determine what laws they will approve. Our subject, therefore, takes on a somewhat simple form, namely, that only state senators and assemblymen of good character and judgment, with sound views on the underlying principles of the public health, be elected, if the interests to which we are committed shall be conserved.

* * *

Little Danger from Legislators of High Type.—With legislators of high type, there is little to fear, since their votes will be cast in favor of all legitimate interests and objectives, provided the same be properly presented.

Organized Medicine in California, as the spokesman for Scientific Medicine and the Public Health, has been obliged, every two years, to scan carefully the hundreds of prospective laws submitted at each legislative session, to make certain that no proposed statutes were included, which openly or furtively could have done serious damage to either public health interests or the practice of scientific medicine.

* * *

Special Obligation to Colleagues in Military Service.—To this obligation may be added the following: that physicians who remain in civilian practice now have a special responsibility in these matters, since those of us who are still at home must guard not only our own personal interests, but the rights of those of our fellows who are in the Medical Corps of the Army and Navy; and who, when they return to resume civilian practice, must take up again under disadvantageous conditions, the development of their personal practices. Physicians who, in days gone by, have been forced to build anew their personal practices that were lost somewhat through absence, can appreciate that such experiences may be neither pleasant nor remunerative.

* * *

Primary Election: Attitude Towards Candidates.—In California, the primary election will be held on August 25th. As usual, in every district, there will be aspirants for the offices of State Senator and State Assemblyman. However, regarding the primary stage of the election procedure, it is not wise to make partisan commitments or espousals of this or the other candidate; and especially so, under the name of a scientific medical society. Whatever support is given, should be through individual action, as from a private citizen. Also, if a number of acceptable candidates are available, it is probably wise not to over-promote one such, to the detriment of the others, lest, perhaps, a wrong guess be made, so that the successful candidate, who was not previously espoused, changes, through unfortunate prior opposition, from a possible friend into the rôle of an antagonist.

In the primaries, therefore, it is best to show

interest through individual action, securing if possible, for future record and use, all available information concerning the background and other attributes of each candidate, but avoiding outright, organized support or opposition.

* * *

Final Election: Preferable Course of Action.

—Once however, the primary election is over, and the candidates for the two or more political parties have been determined by vote of the electorate, special endeavor should then be made not only to secure all the information above indicated, but other data, in addition. For instance: who is the personal physician of each of such candidates; and who, among the Doctors of Medicine in a Senatorial or Assembly district, has the most intimate personal relationship with the candidates? That being decided, an effort should be made, through such physicians, alone or with proper members of the local society, to learn what are the reactions of the candidates in relation to basic principles concerned with the conservation of the public health and proper standards of healing-art practice.

Regarding such interviews, it should be remembered that candidates are not permitted to make preliminary election pledges concerning proposed legislation of specific nature. It is, however, always in order to discuss basic principles. But after all, only that is what the medical profession is interested in, namely, the fundamental principles concerned with the protection of the public health and proper standards of practice.

* * *

Past Rôle of the Medical Profession in Legislative Matters.—For many years, physicians of California have seen one legislature after another convene, with comparatively few measures sponsored by the Doctors of Medicine. In fact, the profession may be said to partake somewhat of the party, "His Majesty's Opposition," as exemplified in the English Parliament, in that the profession is recurrently called upon to fight antagonistic legislation of detrimental nature, rather than to promote laws of its own making.

* * *

Proper Understanding of These Relationships Desirable.—It is well to keep these foregoing facts in mind, since they explain upon what basis is founded the obligation of physicians to take an interest, not only in the election of legislators on August 25th and November 3d, but also in prospective laws that will be submitted to the California Legislature in the first and subsequent weeks of the year 1943.

The hope is also expressed that many physicians may be inspired in this war year, 1942, to take a somewhat closer interest in our state elections than at former biennial periods.

Likewise, that they may keep in mind, that they do this not so much for themselves, as for the profession of which they are disciples, a profession whose many sons are now battling for us

all throughout the world, wherever duty may have called them.

* * *

Basic Science Law will be on the November 3d Ballot.—By now, every member of the California Medical Association should be aware of the fact that the proposed Basic Science Law will be on the November 3d ballot as Proposition No. 3. In last month's issue of *CALIFORNIA AND WESTERN MEDICINE*, on pages 4-6, the Basic Science Law was discussed at some length. And if any member did not notice the comment, the hope is expressed that he will take the time to scan the story there outlined.

The Basic Science proposition, at the end of some twenty years of endeavor, is now on the ballot. It will become a law if the voters are made acquainted with its beneficent purposes. The campaign of education cannot be passed over to others. This is a measure that was espoused and promoted by the California Medical Association in an effort to provide additional safeguards in the conservation of the public health. To secure the approval of the California electorate, especially in times such as the present, a strenuous educational campaign will be necessary. Every physician, therefore, has in this matter a very distinct responsibility, of which he is here reminded, lest in the performance of his daily, routine work, he forget his obligations to the people of California, his profession, his fellows who are overseas, and himself. Develop the habit of talking, "A Basic Science Law for California," from now on. That is one way of making an educational campaign become productive of results.

MEETINGS OF MEDICAL ORGANIZATIONS:
(a) COUNTY SOCIETIES; (b) HOSPITAL
STAFF MEETINGS. WHICH SHALL
HAVE PREFERENCE?

Why the Reminder to Attend Meetings of Medical Societies?—Many members of the medical profession are only occasional attendants at meetings of their respective county medical societies and it becomes necessary, from time to time, to suggest to them, that it is largely through organized medicine, that scientific medicine—implying by that term the practice of medicine as it has been and still is carried on—has been able to do much of its work in the promotion of medical progress. It is good to remind ourselves of this fact, even though to some of our colleagues who find special pleasure in worshipping at the altar of superscience, such a statement, so bluntly put, may be received with skeptical nonapproval. We should be grateful, each and all of us, that of the 180,000 licensed nonsectarian practitioners in the United States, some 120,701 physicians—through membership in the hundreds of component county units of the constituent state associations composing our national federacy—have their names on the roster of the American Medical Association.

Pleasing though that thought may be, however, such massive numerical membership may not mean very much, if judged by the standards of real service. To pay annual dues to a society, a club or other organization is nothing of which one need be inherently proud. Such demands or assessments on the pocketbook, in themselves, only have significance if so to contribute involves denial of real needs or comforts.

* * *

What Good Membership Implies.—Membership in any group, in order to be of value to self and others, implies actual participation in its activities and the attainment of its objectives. Because the purposes of our component county medical societies are dedicated to ideals of great worth—the advancement of healing-art knowledge and the greater protection of the public health—it is the more regrettable that so many physicians permit themselves to develop a habit of nonattendance at the meetings of their local medical units.

The majority of the county medical societies hold only one meeting each month, or a total of about ten to twelve evenings in a year of 365 days. Yet many members defend their habitual nonattendance with one or other of a multitude of specious excuses. The practitioner who is battling for initial place, or who receives a call at the meeting hour, may be pardoned when he is absent. Many of the others, who choose their leisurely comfort in preference to contact and exchanges of opinion with colleagues, and make it a business not to turn out at the monthly gatherings, have no such excuse. A particular group of nonattendants who are worthy of criticism are those, who through greater success in life and fortunate backgrounds, are in position to be of special help to their fellows, but who show little interest in the profession's group affiliations.

The point here emphasized is this: that very few physicians are themselves such superlative individuals, in either knowledge or practice, that, without the good will and coöperation of colleagues, it would have been possible for them to have attained the stations in their communities which some of them are fortunate enough to occupy. If this be the case, then such colleagues should feel under special obligation to meet with their fellow members, to take part in the promotion of programs for both the scientific and organization sessions of their county societies. Coming back, now, to the initial statement that scientific medicine prospers, as it exists today, largely through the protection and aid of organized medicine, it follows that every member of the profession should give more than lip-service or dues-payments to the development of the societies, which collectively, constitute what is called, *Organized Medicine*.

Particularly is this true at the present moment, when those of us who remain at home must safeguard the interests of our fellows who are in the Medical Corps of Army and Navy. Let us all

resolve, therefore, if we have been carelessly or otherwise negligent in attendance at county society meetings, to improve in this respect.

* * *

County Society and Hospital Staff Meetings.

—One more thought, in relation to meetings of hospital staffs. In recent years, in order to promote higher standards in hospital service—through individual and collective effort and the work of attending staff members—much thought has been given to meetings of hospital staffs, mandatory attendance being required in some instances. Excellent and valuable as are such gatherings, however, they should not occupy a place paramount to that allocated to the county medical societies. Let it not be forgotten, that hospitals also need the support of organized medicine, and when their interests are endangered, they turn to the local and state societies for advice and support.

* * *

County Society Officers Should Plan Programs Now.

—Officers of county medical societies and their program committees also have responsibilities, since poor or hastily gotten-up presentations and papers, perhaps of only mediocre or lesser worth, are not sufficient compensation to listeners who may have disarranged their schedules in order to be present. The midsummer postvacation meetings will soon begin, and committees in charge should meet now, and outline, in at least skeleton form, the general nature and scope of the programs for the fall and winter months. Such consideration and prearrangement may go far in securing a better attendance than would otherwise be possible. The truth of this has been shown in many societies, the meetings of one year being excellent and well attended, and in another year the reverse, according as the officers in charge gave time and thought to adequate preparation. Good programs cannot be drawn out of the thin air. They must be carefully arranged, and in advance. Officers and program committees, having been honored through official positions, should do their bit in this, and strive to meet these responsibilities. Good attendance at the meetings of county societies will make it possible for organized medicine to do its work to better advantage. Excellent programs will promote such better attendance.

ON VARIOUS TOPICS: A. M. A. SESSION—FATE OF TWO C. M. A. RESOLUTIONS; INSTITUTES ON WARTIME INDUSTRIAL HEALTH; TRIBUTES TO THE MEDICAL PROFESSION BY CALIFORNIA NEWSPAPERS; TUBERCULOSIS SUPPLEMENT IN THE JULY NUMBER OF C. & W. M.

A. M. A. Session: Fate of Two C. M. A. Resolutions.—In Atlantic City, where the American Medical Association in June last held its 93d annual session, two resolutions were pre-

sented by C. M. A. delegates, in accordance with instructions given by the House of Delegates of the California Medical Association at the recent Del Monte meeting on May 6th.

The minutes of the C. M. A. House of Delegates appeared in the July issue of CALIFORNIA AND WESTERN MEDICINE, and the hope is expressed that many members have taken the time to at least scan the pages, 59-91, which record the proceedings, and to acquaint themselves with the matters in which our component county societies are interested.

Special mention may be made of the following resolutions: (a) Relations between Physicians and Insurance Companies, by Dr. Garland (pages 67 and 87); and Rebates, by Wilbur Bailey (pages 67 and 87). These resolutions were presented to the House of Delegates of the American Medical Association, the first by Delegate Kinney (see J.A.M.A. of June 27, on pages 725 and 728) and the second, on Rebates, by Delegate Wilbur (see J.A.M.A. of June 27, on pages 724 and 728).

Because of their importance, excerpts from the reports of the Reference Committees to which these resolutions were sent, appear in this issue, in order that members of the California Medical Association may know what action was taken by the national organization*.

* * *

Institutes on Wartime Industrial Health.

In the July issue of CALIFORNIA AND WESTERN MEDICINE, on page 101, in the Postgraduate Activities department, appeared a preliminary announcement and outline of a tentative program for meetings to be held as follows:

San Francisco on August 18 (Tuesday).
Crockett on August 19 (Wednesday).
Oakland on August 21 (Friday).
San Diego on August 25 (Tuesday).
Inglewood on August 26 (Wednesday).
Glendale on August 27 (Thursday).
Huntington Park on August 28 (Friday).

The current issue, in the Postgraduate department, presents additional information. The importance of increased interest and knowledge concerning industrial diseases and injuries cannot be gainsaid. All concerned—governmental authorities and citizens alike—are fully aware of the significance of maximum output in essential industries, if our Country is to fight on to Victory. But that desired output will be possible only if fellow citizens who are engaged in such work are kept in best physical condition, so that every available man- and work-hour may count and be of service in the struggles ahead.

The Institutes on Wartime Industrial Health are sponsored by three organizations, which have united their efforts in a desire to secure best results: California State Board of Public Health, California Medical Association, and Western Association of Industrial Physicians and Surgeons.

Coöperation of officers and members of com-

* For A.M.A. proceedings, see page 151.

ponent county societies in the districts to be visited is requested. Members are urged to arrange their schedules to permit attendance at both afternoon and evening meetings, for the time will be well spent. Here is an opportunity for every physician still in civilian practice, to show his willingness to aid in carrying through our war efforts to successful conclusion.

* * *

Tributes to the Medical Profession by California Newspapers.—Were you among those who by chance noted the editorial and other excerpts taken California newspapers, printed in the July issue on pages 109-110, and containing complimentary comment on the contributions now being made at the battle and home fronts by the medical profession; and, if so, was it not a bit gratifying to realize that the work of physicians is really appreciated in many places?

It is unfortunate that physicians are often negligent in maintaining cordial, social and other relationships with the editors of local newspapers. It should not be forgotten that successful newspaper publishers are usually keen students of human nature. Otherwise they would not be able to sense or mold public opinion.

If you are acquainted with the editors of your local publications, why not maintain contacts, and on occasion express to them the appreciation of the profession for their kindly thoughts? It will be easier then to confer with them when public health issues are at stake.

* * *

Tuberculosis Supplement in the July Number of C. & W. M.—Mention has been made above of the joint endeavors of the C. M. A. and two other agencies, concerning publicity designed to promote interest and attendance at the Institutes of Wartime Industrial Health. In last month's issue of our OFFICIAL JOURNAL, in the Tuberculosis Supplement (pages 19-58) appeared another example of such coöperative work. Readers, therefore, who failed to note the articles have denied themselves an opportunity of securing a rapid survey of the latest work in tuberculosis diagnosis and therapy, as presented by California and other colleagues. The almost two score papers (of which there is an index on page 19 of the July issue), some in full but most in digest form, are worthy of more than casual inspection. Many readers will no doubt wish to lay this number aside for special future use and reference. The California Medical Association was happy to participate in the effort to bring to the attention of the physicians of the State the outlines of the excellent papers read at the joint meeting of the California Tuberculosis Association and California Trudeau Society, in April last.

The observer listens to Nature; the experimenter forces her to unveil herself.—*Cuvier*.

The life line varies inversely with the waist line.

The Greeks had a word for high living: Hyperpiesis.

EDITORIAL COMMENT†

"SPONTANEOUS" AVITAMINOSIS

Production of "egg-white injury," or "secondary biotin deficiency" in human volunteers is currently reported by Sydenstricker¹ and his colleagues, of the University of Georgia and the National Institute of Health.

The indigestibility of raw egg-white was first described by Steinitz in 1898, and afterwards studied in detail by Bateman,² who found that ingested raw egg-white is given off almost quantitatively in the stools (dogs, rats, rabbits and man) and exerts a mild toxic effect, as shown by the accompanying diarrhoea and progressive loss of weight. He attributed the indigestibility and resulting toxic effects to the antitryptic action of raw egg albumin. The toxic effects were studied in greater detail by Boas³ about twenty years later, who found that rats fed an adequate, well-balanced daily ration, except for a large excess of raw egg as the source of protein, developed a peculiar dermatitis, accompanied by a gradual loss of weight, which eventually proved fatal. Similar "toxic" symptoms were afterwards demonstrated in the chick, guinea pig, rabbit, monkey and dog fed an excess diet of raw egg-white. Fractionation of the egg-white soon led to the conclusion that the toxic agent is in the albumin fraction; conceivably a toxalbumin of teleological significance.

Boas found that aqueous extracts of yeast, and of many vegetables, are able to prevent or cure the "toxic" symptoms. The presumptive "natural antitoxin" in these foods, originally designated as "protective factor X"³ or "vitamin H," was afterwards shown by György⁴ to be identical with biotin. Applying newer methods of biotin assay, György⁵, and his colleagues developed a logical and consistent theory as to the dynamics of "egg-white injury." They found that uncooked egg albumin is capable of inactivating biotin in vitro, due to the formation of a fairly stable and relatively undigestible biotin-albumin complex, and suggested the term "avidalbumin" or "avidin" for the "toxic" factor. The "toxic" effects were presumably due to its power of binding or inactivating biotin, thus preventing adequate intestinal absorption of this necessary vitamin. "Egg-white injury" thus became a "spontaneous avitaminosis," due to gastro-intestinal "biotin blockade." Tissue assays invariably showed a marked biotin deficiency in egg-white injured animals, in spite of adequate biotin in the ingested food.

In order to determine whether or not a similar "biotin blockade" is possible in man, the University of Georgia research group placed a small

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

group of human volunteers on a diet consisting of polished rice, patent white flour, farina, cane sugar, lard, butter, and lean beef, having a total daily food value of 1960 calories. To this was added 200 gm. of dehydrated raw egg white with a caloric value of 928, plus adequate supplementary amounts of thiamin chloride, riboflavin, nicotinic acid, vitamin A, ferrous sulphate and calcium lactate.

After about three weeks on this diet all volunteers developed a fine scaly desquamation of the skin, which however disappeared spontaneously in seven to ten days. During the seventh and eighth weeks all subjects showed a pronounced grayish pallor of the skin and mucous membranes, with a return of the fine branny desquamation by the ninth week. Mild depression progressing to extreme lassitude, somnolence, and mild panic state was noted in most subjects, accompanied by muscular pains, hyperesthesia, localized paresthesias, anorexia and occasional nausea. There was a definite diminution in the hemoglobin content of the blood, a striking rise in serum cholesterol, and a marked diminution in biotin excretion in the urine. The four subjects excreted an average of about 5 micrograms of biotin daily, as compared with their previous excretion of 40 micrograms.

Vitamin therapy was begun on the tenth week. This took the form of a daily injection of 150 micrograms of commercial biotin concentrate. Within 3 to 5 days after beginning this therapy the depression, muscular pains, precordial distress and anorexia were abolished, the ashy pallor of the skin disappeared, the serum cholesterol was reduced to normal and the daily urinary excretion rose to 55 micrograms biotin. Sydenstricker and his coworkers conclude from these results that human volunteers, maintained on diets containing adequate amounts of vitamins, iron and calcium, may develop "spontaneous avitaminosis," if approximately a third of the daily caloric intake is supplied by dessicated egg white. As in lower animals this apparent egg-white toxicity is presumably due to gastro-intestinal conjugation of biotin with "avidalbumin" or "avidin," which functions as an "anti-biotin."

It has long been a practice of poultry raisers to add charcoal to poultry feeds, under the impression that charcoal adsorbs bacterial toxins and other putrefactive products, and thus improves health and reduces mortality. Almquist and Zander⁶ of the University of California, however, have shown that the addition of 2 per cent charcoal to a basal diet, containing adequate (but not excessive) amounts of all necessary vitamins, almost invariably leads to a somewhat similar "spontaneous avitaminosis." Stunted growth, "curled-toe paralysis," incoördinations, multiple subcutaneous hemorrhages, prolonged clotting time and eroded gizzard lining are among the manifestations noted in charcoal-fed chicks, pointing to a multiple avitaminosis. This deduction was confirmed therapeutically, since each of these manifestations was prevented or cured on the oral administration of the appropriate vitamin, or

by changing to a commercial mash containing a considerable excess of this vitamin. Presumably charcoal has the property of adsorbing numerous vitamins from the gastro-intestinal contents, thus preventing adequate vitamin adsorption from the intestinal contents.

Thus far the phenomenon of gastro-intestinal fixation or inactivation of vitamin has been of little clinical interest except in cases of prolonged and habitual use of mineral oil laxatives. It was shown by Burrows and Farr⁷ that the addition of as little as 1.3 per cent mineral oil to a well-balanced diet causes lethal, vitamin A deficiency in rats, death taking place in about three weeks. There is also⁸ adequate evidence of an intestinal inactivation of vitamin D. Demonstration that an excessive diet of raw eggs may be equally deleterious is therefore of suggestive clinical interest.

In order to prevent popular misconception, however, it might be well to emphasize the fact that adequate cooking destroys the "avidin" or "anti-biotin" in raw egg, and that its apparent "toxicity" is readily prevented by such biotin-rich foods as cabbage, spinach, liver, kidney and cow's milk. It is known that egg yolk is very rich in biotin, but unfortunately it contains only half the amount of this essential vitamin necessary to neutralize the "avidin" or "anti-biotin" in the accompanying egg albumin.⁹

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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IMMUNOLOGIC EFFECTS OF SYMPATHECTOMY

After a year's wartime delay, studies of the effects of total sympathectomy on natural immunity and specific antibody formation in animals have been reported by Went and Lissak¹ of the Physiological Institute, Debrecen University, Hungary.

For two decades the rôle of the nervous system in specific allergic and immune reactions has been of theoretic interest. Experimental evidence has been reported by European investigators, suggesting the existence of a specialized "immunity

center" in the brain, initiating or coördinating specific antibody formation. Schamburów² of the Moscow Clinical Institute injected *E. coli* and *E. typhosa* vaccines into the anterior chamber of the right eye of rabbits, and reported a local synthesis of specific agglutinins in the injected eye, with their "reflex" synthesis in the opposite eye. In many of his rabbits only a trace of agglutinin was demonstrable in the blood stream with many multiples of this amount in the non-injected eye. He translated these data as proof of a reflex local antibody synthesis by non-vaccinated tissues, presumably through a hypothetical "immunity center."

Although his alleged "reflex ocular immunity" could not be confirmed by American investigators,³ the probable rôle of the sympathetic nervous system in specific antibody formation has been quite generally affirmed. As early as 1898, Salomonsen and Madsen⁴ demonstrated a marked increase in antitoxin titer in horses as a result of the administration of parasympathetic stimulants (pilocarpin). Joachimoglu and Wada⁵ afterwards reported the opposite effect, a reduction in specific agglutinin production in rabbits as a result of the administration of parasympathetic depressants (atropin). In a recent summary of accumulated data Belák⁶ concluded that in their relationship to the autonomic nervous system antibodies can be divided into two groups: (i) a "sympathogenic group," including complement and normal opsonins, which are favored by sympathetic stimulants and inhibited by the parasympathetic, and (ii) a "parasympathogenic group," including antitoxins, precipitins, and bacteriolysins, which have the opposite relationship, being favored by the parasympathetic stimulants and inhibited by the sympathetic.

This division of antibodies into two neurogenic groups was of little practical interest at the time. With the development of the modern surgical practice of regional sympathectomy, however, the theory became of practical clinical value. The experimental evidence in support of the neurogenic theory of immunity was, therefore, reëxamined by the Hungarian physiologists. They found the pharmacologic evidence inconclusive due to the presumptive direct toxic action of atropin, pilocarpin, etc., on antibody-forming tissues. To obtain conclusive evidence, Went and Lissák performed total sympathectomy on a group of cats, the operation being performed in several stages by the Cannon⁷ technique. Four to six weeks after complete recovery from the last stage of the operation, blood samples were titrated for complement and bactericidal power, *E. coli* being used as the test organism. Control titrations were made with an equal number of non-operated cats. Within the limits of the experimental error, the complement and colicidal titers were identical in the two groups. From this it was evident that the integrity of the sympathetic nervous system is not essential for the production and maintenance of

normal serum titer. Alterations of serum titer reported by previous investigators as a result of the administration of sympathetic stimulants or depressants are presumably due to direct toxic action on extra-neural tissues.

The same group of sympathectomized cats was afterwards tested for their ability to synthesize specific antibodies. Foreign proteins and non-viable bacterial vaccines were injected into these cats, with control injections into an equal number of normal cats. With the limited number of sympathectomized animals for such tests, no qualitative or quantitative differences were demonstrable between their power to synthesize antibodies and the production of the same antibodies in normal controls. From this they concluded that the sympathetic nervous system plays no rôle in the production or coördination of acquired humoral immunity.

Their data suggest that regional sympathectomy is without deleterious effect on natural or acquired immunity, and would be of no benefit in regional anaphylaxis. It should be emphasized, however, that their studies were confined to the humoral factors in immunity and anaphylaxis. With the obsolescence of the Ehrlich side-chain theory⁸ it is no longer axiomatic that humoral and cellular chemical defenses are either qualitatively or quantitatively identical. Effect of sympathectomy on fixed tissue defense is still an open question.

W. H. MANWARING,
Stanford University.

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MALPRACTICE PROPHYLAXIS

It is fundamental that every patient be cared for with meticulous attention to the requirements of good medical practice. This comprehends sufficiency of investigation, observation and treatment; utilization of every indicated laboratory aid; protection of those coming in contact with the patient; instruction, when necessary, of the patient and of those caring for the patient, so that all things needed may be carried out during the absence of the attending physician; recognition of the importance of psychological

factors so that the nervous, mental, and emotional balance of the patient may be constructively influenced by tactful handling and the institution of proper psychotherapeutic measures; making and preserving of a complete and accurate record of the history, examination, treatment and progress of the case.

It is also fundamental that, in undertaking the care of patients, the physician should accept only such cases as he is well qualified to handle. The physician must keep abreast of progress in his field, and should utilize accepted and recognized procedures. In any case, if the patient is not doing well, or is complaining or expressing dissatisfaction, a consultant should be brought in. The use of a consultant affords great protection in the event that a claim of malpractice is later made. It is recommended that protective use of consultants be made routine, even in cases where a consultant's fee may not be available. It is also important to exercise care in delegating duties to assistants, nurses, and technicians; and in maintaining professional instruments and apparatus, as well as a safe environment in which to work. Instruments should be checked and apparatus calibrated as required in the exercise of ordinary care.

It must be recognized that it is hazardous to sterilize any patient in the absence of a medical indication; that it is dangerous to telephone a prescription, because of the possibility of error in transmission; and that, without taking legal advice, it is unwise for a physician to testify at a coroner's inquest in a case wherein which he has been in professional attendance.

In any consideration of malpractice prophylaxis, keeping good medical case records is the most important single factor. It is desirable that a physician ask himself, from time to time, what he would wish to have in the record in the case under treatment, in the event that he should later be called upon to justify his conduct of the case in court. "Ideal" medical case records should be kept in every instance—records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that indicate that nothing was neglected, that the care given fully met the standard demanded by the law. In the event that any patient discontinues treatment before he should or fails to follow instructions, let the record show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course. The records should, of course, also contain the laboratory reports, consultant's reports, and certain miscellaneous forms which are necessary or desirable in particular cases, such as consent to operation, consent to autopsy, copies of reports required to be made by law; acknowledgment of hazards of particular procedures (shock therapy, fever therapy, x-ray therapy), etc.

The importance of tact can hardly be overemphasized. It should be manifest especially in

the handling of the patient and the patient's family; in the avoidance of fee disputes, and unwise efforts and methods in the collection of fees (considering the provisions of the Statute of Limitations); in the avoidance of over-optimistic prognoses and, especially, of any promise constituting a guarantee of a particular result; in the avoidance of betrayal of privileged communications; in the avoidance of making any statement constituting, or which might be construed as, an "admission" of fault or negligence; in the avoidance of any reference to malpractice insurance protection; in the securing of legal advice before making any statement in regard to a malpractice claim or suit; etc.

A physician is not required to accept any patient. However, once the physician-patient relationship is established, the physician must give, or see that there is given, such care and attention as the case requires until the professional service is no longer needed, unless he is sooner discharged by the patient or unless he withdraws from the case. The physician may withdraw from the case, but he must first give reasonable notice, and there must be reasonable opportunity to fill his place. The fact that a physician is unable to attend a patient who needs him, merely because he is busy with other patients, will not relieve him of liability if the patient thereby suffers injury. It is desirable that a physician advise his patients of any intended absence from practice and that he recommend, or make available, a qualified, independent substitute.

The precipitating cause of a majority of all malpractice actions is found in the destructive comments or criticism of physicians in regard to treatment given to patients by other physicians. Commonly it is criticism by a succeeding physician of the work of his predecessor on the case. Legitimate criticism can rest only on full knowledge of the facts as gathered from all parties, from the physician who treated the patient as well as from the patient. Unethical criticism must be avoided.

An examination of the cases reveals the significant fact that malpractice claims arise almost invariably out of the first course of treatment. In other words, it is rare indeed that an old patient instigates suit against his physician. It follows that the physician should be "malpractice conscious," especially in dealing with the new or casual patient. Prevention is the best defense against malpractice actions.

6777 Hollywood Boulevard.

LOUIS J. REGAN,
Los Angeles.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 145.

ORIGINAL ARTICLES

Scientific and General

MARCH FRACTURE*

A REPORT OF FIFTEEN CASES

MAJOR A. B. SIRBU, M. C., U.S.A.

AND

CAPTAIN A. M. PALMER, M. C., U.S.A.

Fort Ord

THE literature during the past year has begun to show some reports of a foot disability prevalent in soldiers and variously known as March Fracture, March Foot or Pied Force. This is not surprising, considering the fact that our military training program is now over eighteen months' old. Since Breithaupt, in 1855, first described the occurrence of localized, painful swelling in the feet of marching soldiers, we find mention made of the condition by medical officers of most armies. Pauzat and Poulet, independently, each described an insidious periosteal proliferation in the French Army in about 1880, and Stechow¹ made the first x-ray studies of the condition in 1897 with remarkably accurate observations.

Subsequently, a number of reports came from French and German authors. Surprisingly, there were no cases reported in this country, even during the last war. As a matter of interest, the first case of "March Foot" reported in the United States was that by Goldman in 1928. About that time isolated reports began to come from civilian

and etiology of this unusual condition. Is it a fracture or a tumor? Is it inflammatory, infectious or traumatic? Which comes first, the fracture or the periosteal proliferation? Some of the confusion and differences in opinion are undoubtedly based on the fact that so few cases were observed by any individual author. Furthermore, different stages of the condition present entirely different findings, especially by x-ray.



Fig. 3A and 3B.—Case 5.—AP and oblique views, 5 days after onset of symptoms.

Thus, Stechow and Kirschner⁸ were certain that it was a fracture initially, based on abnormal stress and strain, and that continued marching brought on a periosteal reaction with proliferation of callus. Deutschlander insisted he was dealing with a low-grade infection, a periostitis of the metatarsal shaft at the site of the nutrient artery, and so revived interest in the condition that it has been also known as Deutschlander's Disease. Jansen postulated that overaction of the interossei caused an absorption of lime salts, with resulting brittleness of the metatarsal and a secondary fracture. Mercer⁹ also suggests that there is at first a deposit of new subperiosteal bone at the expense of the cortex, and that this is followed by a pathological fracture from additional minor trauma. He even offers, as an alternative name, that of Perimetatarsal Osteoma. Finally, this concept is excellently defended by George Brandt¹⁰ in his work on "creeping fractures, transformation zones and overload injuries," a thorough summary of which may be found in the current Year Book of Radiology.

Notwithstanding these weighty arguments, we hope to show in our fairly representative series that this is a fracture, a stress fracture secondary to a developmental anomaly. In short, we agree that it occurs in young soldiers, unused to the rigors of long marches, but *only in those whose feet are inherently weak or flat, and mechanically unsuited to withstand the exertion which they are suddenly called upon to perform.* The fact that the early crack-fracture is occasionally not seen in x-ray is no criterion of its absence; for, as Watson-Jones¹¹ points out, similar insufficient fractures occur elsewhere in the body, particularly in the carpal scaphoid.



Fig. 1A and 1B.—Case 1.—AP and oblique views, 14 days after onset of symptoms.

practice with excellent reviews by Jansen,² Deutschlander,³ Dodd,⁴ Speed⁵ and Blake, Maseritz⁶ and Meyerding.⁷

As one might expect, much discussion and theorizing have been forthcoming as to the nature

* Read before the Section on General Surgery, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

From the Station Hospital, at Fort Ord, Monterey County, California.

It has occurred to us that the pitfalls and difficulties of differential diagnosis to the unsuspecting observer might best be brought out by describing our experiences with our first case.

REPORT OF CASE

CASE 1.—On November 3, 1940, there came under the observation of one of us (A.B.S.) an eighteen-year-old soldier, who had enlisted just four months previously. He complained of pain and swelling in the right foot of about two weeks' duration. He could recall no specific injury, but rather attributed the onset to an incident of firing on the rifle range in a kneeling position, with undue strain on the right forefoot. The initial soreness became aggravated and associated with swelling after several long marches.

Our original diagnostic error is not surprising when one reads of the number of times that biopsy was necessary to rule out sarcoma, and of the case that Dodd reports where a woman's foot was amputated, only to find a benign March Fracture on pathological examination. We may add to this, with some humor, Watson-Jones' report that a patient's wife instituted divorce proceedings against her husband because she had been erroneously informed that he was suffering from syphilitic periostitis.

OTHER CASES

Since our first experience, over a period of eighteen months, we have observed and treated in

TABLE 1.—March Fracture
Analysis of 15 Cases

Fig. 2.—Table 1.

Name, Rank and Org.			Age	Length Service	Duration Symptoms	Method of Onset	Metatarsal Involved	Length of Disability
1.	H.E.C.	Pvt. Engr.	18	4 mo.	14 da.	Firing in kneeling position, aggravated by march	2 R	25 da.
2.	N.W.J.	Pvt. F.A.	21	3 mo.	14 da.	Foot stepped on. Aggravated by march	2 L	7 da.
3.	E.E.S.	Pvt. F.A.	32	2 mo.	2 da.	Fell from caisson	2 L	17 da.
4.	A.S.C.	Pfc. Engr.	26	4 yr.	2 da.	Tractor ramp fell against foot	2 R	18 da.
5.	L.C.N.	Pvt. Inf.	25	3 mo.	5 da.	No injury. Gradual onset on march	3 L	34 da.
6.	L.B.B.	Pvt. Inf.	20	9 mo.	23 da.	Struck foot with pole	2 R	14 da.
7.	W.A.S.	Sgt. Inf.	20	19 mo.	4 da.	No injury, occurred while on march	2 L	16 da.
8.	E.J.Z.	Pvt. Inf.	28	2 mo.	8 da.	Stubbed foot against stump	3 R	29 da.
9.	A.B.H.	Pvt. Inf.	22	3 mo.	6 da.	No injury. Gradual onset on march	3 L	42 da.
10.	D.W.H.	Pfc. Inf.	30	5 mo.	23 da.	No injury. Gradual onset on march	3 R	42 da.
11.	F.L.R.	Pvt. Inf.	22	7 mo.	17 da.	Twisted foot while on march	2 L	42 da.
12.	E.M.H.	Pvt. Inf.	20	2 yr.	4 da.	No injury. Gradual onset on march	3 L	42 da.
13.	A.S.	Pvt. F.A.	23	4 mo.	10 da.	No injury. Gradual onset on march	3 R	None
14.	M.B.	Pvt. Inf.	19	5 mo.	3 da.	No injury. Gradual onset	3 L	None
15.	E.S.B.	Pvt. Engr.	26	15 mo.	60 da.	No injury. Onset after long march	3 L	14 da.
Average			23.7	10 mo. (11 pt. 4 mo.)	13 da.	11 pt. no injury	7—2nd 8—3rd	21 da.

Examination revealed diffuse swelling over the dorsum of the foot, but close palpation revealed a localized, fusiform thickening (of bony consistency) of the shaft of the second metatarsal in its distal half. This was rather tender to pressure, but otherwise he showed no signs of acute inflammation or infection.

The x-ray findings are of prime importance. (Fig. 1A and 1B.) These were interpreted as showing destruction of the cortex of the distal shaft of the second metatarsal and elevation of the periosteum, with new bone formation in a laminated pattern. A tentative diagnosis was made of Ewing's sarcoma, based on the periosteal reaction, the "onion-peel" appearance of the new bone and the absence of fracture. Fortunately, additional observation, plus a rapid recession of swelling and tenderness under the simple régime of bed rest, elevation and compresses, made us weaken in our diagnosis. Then we rediscovered the reprint of an article by Speed and Blake on so-called March Foot, in which it was brought out that, in one stage of the condition, the x-ray findings are indistinguishable from Ewing's sarcoma. The eventual progress of the case, with complete disappearance of symptoms and consolidation of the callus, substantiated our revised opinion.

the Station Hospital at Fort Ord, California, fifteen cases which have justified the diagnosis of March Fracture. This number constitutes twenty-five per cent of all fractures of the metatarsals (60) which we have seen during the same period. It further constitutes but two per cent of all fractures (618) treated in our service. Considering the condition as nontraumatic, it represents four per cent of the symptomatic foot disabilities (449) which have come to our attention.

CHARACTERISTICS

Certain characteristics of these cases are brought out by Table 1 (Fig. 2). All of the cases were enlisted men attached to field or tactical units, the training program of which calls for long marches and frequent drilling. As a rule, they were very young men with an average age of 23.7 years. The length of service since induction or enlistment was relatively short, the average being ten months. It must be noticed that this figure is greatly lengthened by but four men of over one year's service, whereas the large majority, eleven cases or seventy-three per cent, had but four months' service in the Army. As such they may be considered as recruits, which bears out the experience of Wilhelm¹² (with German soldiers during the Polish campaign), that March

Foot is noticed at the beginning of training of young soldiers who have never participated in sports or strenuous exercise. The previous occupation of our group was either sedentary or physical labor, which required no prolonged, exhaustive hiking or rhythmic marching. Wilhelm also suggested that the prevalence of the condition in the German Army might be the result of the rigid cadence they are wont to employ. In the Italian Army, where the gait is less rigid, very few cases have been reported.



Fig. 4A and 4B.—Case 5.—Three weeks after onset of symptoms.

The gradual onset of symptoms is demonstrated by an interval between the initial soreness and date of admission to the hospital. This averaged thirteen days, during which time the majority continued to perform their usual duty, which included additional marching. Some discussion may be brought out by the alleged method of onset. In spite of the fact that many patients are prone to recall some injury as the cause of their disability, eleven of these cases, or seventy-three per cent, could volunteer no specific incident of trauma. The remainder claimed comparatively minor accidents, stubbing or bumping of the foot, insufficient to warrant immediate medical attention. All of which would tend to substantiate the general claim that this is a marching fracture caused by rhythmic movements, multiple mechanical insults, or micro-traumatism. Furthermore, continued prolonged weight-bearing could cause dissemination of the fracture hematoma and excessive callus formation, as Watson-Jones pointed out.

BONES INVOLVED

The metatarsal involved was the second in seven cases and the third in eight cases. This is a somewhat surprising fact, since the second is generally considered a trifle more prone to injury than the third. Kirschner's cases were divided into 40 second metatarsals and 31 thirds, as well as 1 fourth. *It is our opinion that the predilection for the second and third metatarsals is based on a fundamental conception of the predisposing causes of the condition.* X-ray studies

in every one of our cases revealed a relatively short first metatarsal compared to the second, so-called metatarsus atavicus. Add to this, the fact that the sesamoids, which bear the initial brunt of the takeoff, are even more proximally located and the shortening effect is further increased. The weight, which should be borne by the heavier and stronger first metatarsal, is shifted to the adjacent two metatarsals. The latter are long and slender and ill-equipped to bear one hundred fifty or more pounds plus a heavy pack. The base of the second and third metatarsals is relatively fixed, so that, as the full load is placed on the head, considerable stress is transmitted to the shaft which may crack at its weakest point, usually in the distal or middle third.

COMMENT

These observations are based on the studies of Morton¹³ on the comparative anatomy and evolutionary development of the human foot. In the transition from a grasping to a weight-bearing mechanism the first metatarsal gradually grows laterally to parallel the other metatarsals, loses its mobility and grows in length. It is commonly accepted that the first eventually attains a length which is equal or greater than the second. This is apparently not correct, and the confusion rests with the fact that the great toe generally projects further forward than the others. This is due to the relative size of the phalanges rather than the metatarsal. Lake¹⁴ showed that, while the great toe was longer than the second in sixty-nine per cent of cases, equal in seven per cent and shorter in five per cent, the first metatarsal head projected further forward in only thirty per cent, was equal to the second in ten per cent, and shorter in fifty-two per cent of cases. Our x-ray studies tend to

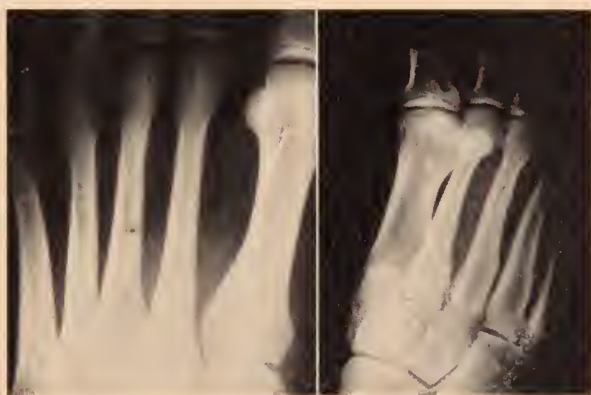


Fig. 5A and 5B.—Case 12.—AP and oblique views, 4 days after onset of symptoms.

corroborate these findings in general, and lead us to believe that the accepted conception of a normal foot may have to be altered.

From a developmental standpoint, however, in those individuals where the first metatarsal fails to reach at least a comparatively equal length, a potentially weak foot results, the so-called atavistic

foot. The posterior located sesamoids, as previously mentioned, tend to increase the shortening effect and a pronation of the foot occurs. With increased exertion on this structurally weak foot, the problem of fatigue of intrinsic foot muscles and relaxation of ligaments becomes important. Thus March Foot may be considered as an end result of subacute flat foot occurring in a congenitally weakened foot.

This developmental anomaly is not only noticed in all of our cases, but also appears to have been present in all reports in the literature where satisfactory x-ray studies are presented. Either the first metatarsal is shorter than the second (metatarsus atavicus) or it has not reached the parallel position (metatarsus varus). In either case the same result occurs, that of shifting an abnormal degree of weight to the heads of the smaller metatarsals. It was noticed, in one of Meyerding's cases, that the fracture occurred in a woman who had had a resection of the first metatarsal head at a bunion operation, thus definitely diminishing its length.



Fig. 6A and 6B.—Case 12.—Six weeks after onset of symptoms.

Barring the complication of a March Fracture, this type of foot tends to compensate for its inherent weakness as middle age is approached. The second, and occasionally the third, metatarsal hypertrophies under the continued strain of excessive weight. We have a number of films to substantiate this observation of Morton's in attempting to account for causes of pronation, metatarsalgia and allied static foot disorders.

TREATMENT

Treatment will be mentioned only briefly. Swelling and pain disappear rapidly when the foot is put to rest. Although a cast may be used, we have not found complete immobilization necessary. A metatarsal pad and strapping to relieve the weight from the head of the afflicted bone, is usually sufficient. To this is added an anterior heel or metatarsal bar to the shoe. Local heat, whirlpool, light massage and exercises to tone up the foot muscles are beneficial. The length of disability (average twenty-one days), is relatively longer in a military organization where a soldier must either be in the hospital or on

duty, which may call for premature hiking. No after effects have been noticed and no recurrences seen in our series.

REPORT OF CASES

Two typical case histories are presented with x-ray studies which demonstrate the early and late appearances of March Fracture.

CASE 5.—A private, age 25, with three months' service in an infantry regiment, presented himself with foot discomfort of five days' duration. Previous occupation was given as a lithographer. He gave no history of specific injury, but noticed onset of pain and swelling in the fore part of the left foot after a long march. Symptoms became aggravated with additional walking. The admission diagnosis was pes planus.

Examination was not remarkable except for localized swelling and tenderness, especially over the shaft of the third metatarsal, left foot. X-rays revealed evidence of an early March Fracture. It will be noted that in the A.P. view (Fig. 3A) the only demonstrable pathology was a slight periosteal proliferation about the neck of the third metatarsal. In the oblique view (Fig. 3B) a small, incomplete fracture was visible on the dorsal aspect of the metatarsal at the same site. The first metatarsal is shorter than either the second or third. Also note that the fracture occurs through the slenderest portion of the bone, presumably its weakest point.

Check-up films taken three weeks later (Fig. 4A and 4B) revealed typical periosteal callus formation in a fusiform pattern about the fracture site. The latter is now visible in both views, saucer-shaped with concavity distally and union about complete. Later x-rays revealed complete obliteration of fracture line with condensation and increased density of callus.

CASE 12.—A private, age 20, whose previous occupation was that of a student, came in with pain and swelling in the left foot. He likewise could remember no history of injury, but noticed gradual onset of symptoms four days previously, following a long march. His admission diagnosis was that of "ill-defined condition of the left foot."

Examination revealed moderate swelling over the dorsum of the foot, with tenderness localized about the third metatarsal. X-ray studies revealed very slight periosteal reaction on the medial aspect of the neck of the metatarsal in the A.P. view (Fig. 5A). The oblique view (Fig. 5B) revealed fracture lines through both the dorsal and plantar aspects of the cortex, with early periosteal proliferation. Here, again, we are dealing with a first metatarsal which is shorter than either the second or third. The latter is long and slender with the fracture apparently at its weakest structural point.

Check-up films taken about six weeks later (Fig. 6A and 6B) revealed a fairly large fusiform mass of callus in both views. The fracture is not visible in the A.P. view but may still be seen in the oblique view.

SUMMARY

1. The literature on March Fracture is briefly reviewed, including theories as to possible etiology.
2. Diagnostic problems are stressed, particularly in reference to Ewing's sarcoma.
3. A series of fifteen cases, as seen at one cantonment hospital, is presented with discussion of history of onset, clinical and x-ray findings

and treatment.

4. This group bears out the contention that the fracture is primary, and is related to a static foot disturbance based on faulty anatomical development.

5. A plea is made for the recognition of the condition in the armed forces, early treatment and possible prevention.

Station Hospital, Fort Ord, California.

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DUTY OF THE PHYSICIAN TOWARD THE CHILD IN WARTIME*

LLOYD B. DICKEY, M.D.
San Francisco

IN outlining our present duties toward the child, we may be guided by the questions the anxious mother asks us. What shall I do myself, what shall I have done, to ensure the good health and safety of my child? War is upon us; that we cannot prevent. Pestilence, famine, and death we can largely turn away from the group for which we are fighting the hardest, our children.

INFECTIOUS DISEASES

In wartime these increase despite all efforts at control. This is due mostly to the movements of disturbed populations of men and animals, and breakdown of ordinary and specific methods of prevention. We are closer than ever before to the Orient and to increased contact with smallpox, diphtheria, typhoid, typhus, dysentery and plague. Our facilities for controlling these are excellent. They need only be kept in mind, and

the accepted methods of prevention practiced. We are also in danger of spread of some of these diseases from endemic foci in our midst, and from infection from such wartime diseases as tetanus and rabies. We should be entirely familiar with the methods of producing both active and passive immunity in all these diseases, and particular methods against some of these will be discussed by another speaker at this session. We should be able to answer the question of the mother: What inoculations do you advise, how are they given, when, and why? The efficacy of the generally accepted immunizations is certainly much less debatable in wartime.

We must mention the always increased incidence of tuberculosis following wars, and take measures against its toll. Tuberculosis has typically been spread throughout the world by migrating peoples, both in peace and wartime. In this war considerable numbers of people will come as refugees, evacuees, and returning crusaders from centers where tuberculosis is rife. Its incidence increases when people are crowded together, when food is scarce, and living conditions are generally lowered. All the factors mentioned will increase the number of possible contacts to our own children, and should be a stark warning to us.

Our fight, therefore, against the infectious diseases, points toward: First, intense immunization where possible; second, control of the movements of people and animals that may spread the diseases; third, proper housing, feeding, and health conditions of all humans in our midst.

NUTRITIONAL DISEASES

In this group we have at present facilities and the knowledge to prevent and to treat every medically recognized nutritional disturbance. We need only to be on the alert to use the knowledge we have and transmit it, in anticipation, to the mothers of the children under our care. We can truthfully give the mother reassurance on this score, as the job is comparatively easy. Regimentation itself is not necessary, and probably not advisable. If the Reich's Journal of Public Health can be believed, the infant mortality in Germany was 10 per cent higher for 1940, than in England for the same time. The vitality of the infant Herrenvolk is not impressive.

In this country we shall have few problems of food and children, except in possible cases of sudden evacuation or isolation. The mothers, however, should be prepared for this by education. While not belittling the emphasis on well-balanced diets, it may be remembered that most children, even small infants, if well to begin with, can live in good health for considerable periods of time, and in dire emergencies, on whole, evaporated, or dried milk, if supplemented by Vitamin C and iron. A simple fact to bear in mind is that if protein be given in amounts sufficient for growth, other elements except vitamins and iron take care of themselves. In health, even Vitamin C and iron deprivations take consider-

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From the Department of Pediatric's Stanford University Medical School.

able time to produce disease, except in the case of small infants. In the last war most of the nutritional diseases were caused by lack of food in quantity, and the starving children of Europe would improve almost immediately if given in sufficient amount almost any kind of a single whole grain cereal. In voicing an optimistic note, we should not lose sight of the possibility of contaminated or spoiled foods, and the dangers of botulism, infectious enteritis, or abortus fever. A word should be said for the encouragement of breast feeding for small infants during wartime, especially if danger of evacuation or isolation be imminent. The importance of good nutrition in combating the first group mentioned, the infectious diseases, should be emphasized again.

PSYCHIATRIC DISTURBANCES

These are common among children in wartime, even when far removed from combat zones. Air-raid practice among school children without proper psychic preparation, careless talk from elders, present day radio and cinema entertainment may strike terror into the heart of a child. While discussions and decisions in this field lie properly among the child psychiatrists, all medical people are asked by mothers: What and how much shall I tell my child? While there are many who hold to the view that they should be told all, this point is surely debatable, and might we offer the suggestion that they should be told only when they ask? Is it not true that as nobody knows the answers, the longer the telling be postponed, the more it may become unnecessary to tell them at all? This, of course, is dependent on the maturity of the child, and within reason of safety to themselves. Morbid discussion, and display of fear should at all times be taboo. School and recreational facilities for the child should not be curtailed, and even in times of all-out production, the home life, his anchor to reality, should be as little disturbed as possible. During actual disaster, from English experience, it is known that children stand up in direct proportion to their elders, but we must also remember that in time of actual battle, children are more apt to become casualties without being injured. They may become lost, and injured and ill through wandering, after the battle is over.

RELATION TO NATIONAL DEFENSE

Is there any way in which we may aid in National Offense? In the number of selectees rejected for military service, the reasons for rejection have been largely: first, for faulty dentition, and second, defective vision. In many it was found that there had been evidence of these same deficiencies fifteen years previously. These defects, with others, such as cardiovascular and ear diseases, make up a relatively large group, remedial in part in early life if found by the physician. It is more than possible, and God forbid, that older children now under our medical supervision may see service in the present war. We might

conceivably add to the available manpower later by being on the alert now.

SUMMARY

The duty of the physician toward the child in wartime can be summarized briefly. It is to meet the increased hazards of physical and mental disease by not only doing our present job, but to intensify our work of education and prevention in all its phases. Never before in the world's history have children been cared for so well. It would still be a tragedy to win a military victory and find our children's standard of health lower than when we were attacked.

Stanford University Hospital.

CHEST X-RAY EXAMINATIONS OF LARGE GROUPS*

WILBUR BAILEY, M. D.
Los Angeles

BY general agreement radiographic examination of the chest is usually considered the most trustworthy procedure. Such surveys of large groups of individuals are becoming popular, and may be expected to become even more frequent even after the Army mobilization is over. These surveys made on large groups are really the cheapest possible form of insurance, for by this means cases of early or even advanced tuberculosis are discovered which might otherwise be inducted into the Army or employed by industry. Spillman has estimated that tuberculosis during and after the World War has cost approximately \$960,000,000 to date in compensation, vocation training, insurance, hospitalization. Within the next five years these costs will pass the billion dollar mark.¹ The importance of selecting men without disease of the lungs, therefore, can be easily seen. In other words, each case of pulmonary tuberculosis in a soldier who was in the last war has cost the Government an average of \$15,531 to date,² and the end is not yet in sight. In comparison to such large expenditures, the cost of an x-ray examination is negligible. Ordinarily the cost of x-ray film amounts to only about 20 per cent of the x-ray examination. This figure is not correct, however, when large groups of individuals are examined at one time, for under these circumstances the proportionate cost attributable to film rises considerably. For this reason many compromises have been made recently using films of 4x5 inches (or 4x10 stereoscopic), as well as 35 mm. film. Under these circumstances the fluoroscopic screen has been photographed in order to obtain a reduced image. Film substitutes such as paper have also been employed.

The impression has sometimes been given that satisfactory results and rapid speed of examina-

* Chairman's address. Read before the Section on Radiology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

tion cannot be attained with the standard 14 x 17 size of films.³ This is by no means the case. In our experience the largest part of the time required in any method is consumed getting the patient into the proper position. Since this is the case, standard 14 x 17 radiographs can be produced, therefore, as rapidly as any of the sub-standard film sizes, or even photographic paper in rolls.

PROCEDURE

It must be remembered primarily that greater degrees of speed and efficiency can be obtained when the patients consist solely of coöperative young men, such as Army inductees, than could possibly be reached with mixed groups of individuals. Work can be arranged in a "production line" so that all of the technicians and assistants have relatively simple jobs with which they soon become familiar. Because the human element is involved, the work cannot be made to proceed entirely with mechanical efficiency, but speeds of 100 examinations an hour may become routine, although more than 125 an hour have been attained when medical students were examined, because of the intelligent coöperation of such a group.

The technique with 4 x 5 and 4 x 10 films does not differ greatly than when films of 14 x 17 size are used. Target film distance is decreased—a compromise necessitated by the immense x-ray output required with present photoroentgen equipment. For the same reason kilovoltages are increased so that the working range falls between 70 and 95, while the milliamperes second output must rise to 40 or 60 milliamperes seconds or even more.

The compromises necessitated by the requirements of the present-day photoroentgen units might be expected to produce films of inferior contrast and detail, and, as a matter of fact, they do. High kilovoltages, target-screen distances of 36 to 40 inches, screen grain and coarse focal spots all go to produce poorer detail in the image, while contrast is often objectionably marked. It is to be hoped that contrast will be lessened and detail improved when the single-coated 4 x 10 film comes into general use for photoroentgen work, rather than the duplitized film which is generally being supplied at present. The image on the back surface of the duplitized film is so faint that it serves largely to blur the light transmitted through the film instead of improving the sharpness of the image.

ON ACCURACY OF DIAGNOSIS: SOME COMPARISONS

Whether the inferior quality of the image made with the photoroentgen equipment would affect the accuracy of diagnosis markedly, could be determined by comparing large groups of single 14 x 17 chest films with 4 x 10 stereo chest films. Such a comparison is made below on groups of the same type of inductees with both sizes of films.

13,494 cases were examined on single 14 x 17 films. The findings were as follows:

	Number	Percentage
Group No. 1—Small calcifications (juvenile type)	882	6.5
Group No. 2—Excessive calcifications (juvenile)*	216	1.6
Group No. 3—Active pulmonary tuberculosis	144	1.1

In contrast is a group of 20,629 cases with stereoscopic examinations on 4 x 10 films which showed:

Group No. 1—Small calcifications (juvenile type)	886	4.2
Group No. 2—Excessive calcifications (juvenile)*	182	0.88
Group No. 3—Active pulmonary tuberculosis	274	1.32

A considerable decrease in the number of cases with calcifications appears in the studies made with 4 x 10 films. This is partly to be explained by the fact that the contrast is so marked in the photoroentgen films that soft-tissue shadows—especially in the hilar regions—have almost the same density as calcifications. The latter are, therefore, not indentifiable.

It was surprising to me that the rejections for active tuberculosis of the type in which actual parenchymal infiltration was present, Group No. 3, were as high (or even higher), with the small films as with the large ones. This can perhaps partly be explained by the magnification of small lesions which is apt to occur because of the short target film distance. It must be admitted, therefore, that even though these small films are lacking in many desirable diagnostic qualities, they do, nevertheless, serve as a relatively satisfactory screening method for mass examinations of the chest.

Of the cases of tuberculosis in both series, 47 per cent were classified as "minimal," 42 per cent were considered "moderately advanced," and 10 per cent were diagnosed "far advanced." Whether the inductees had had physical examinations of the chest made previously to x-ray studies or not, did not appreciably affect these percentages of tuberculosis discovered by x-ray.

A further disadvantage of the use of small films is to be found in the relatively long exposures which are now necessary. As a result, motion of the basal trunks often occurs, and it is, therefore, difficult to predict from the small films whether an increase in these trunk shadows is present or not. Similarly the cardiac shadow itself, because of the 36 to 40 inch screen-target distance, may appear to be enlarged, when actually this is not the case.

* Calcifications of the juvenile type, Group No. 2, were rejected according to the standards proposed by the Army Medical School,⁴ i.e.:

1. Parenchymal nodulations—multiple—more than 10 in number or if the diameter of any one be greater than 1.0 cm. or if more than one be larger than 0.5 cm.

2. Lymph node densities—multiple—more than 5 in number or if the diameter of any one be greater than 1.5 cm.

CONCLUSIONS

1. The detail in 4 x 10 films is considerably less than the best attainable on 14 x 17 films, and little can be said about heart size because of the short target-screen distance. The films are, nevertheless, more satisfactory than might be expected for the purpose of finding active tuberculosis in mass examinations.

2. In the accompanying tables a large number of cases which were examined with single 14 x 17 film are compared with groups of similar individuals examined stereoscopically with 4 x 10 film in the photoroentgen unit. The percentage of active cases of tuberculosis discovered was a little higher with the stereoscopic 4 x 10 films.

2069 Wilshire Boulevard.

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WAR SOFT TISSUE WOUNDS AND THEIR COMPLICATIONS*

JOHN HOMER WOOLSEY, M.D.
Woodland

SOFT tissue wounds obtained under war conditions differ from those of peacetime accidental nature and, primarily so, because of the effect from the greater causative tearing and contusing force. As a result of this, a more widely distributed tissue injury occurs and demands a more complete, and to the uninitiated a far more radical, surgical treatment than employed in the correction of the usual peacetime traumatic wound.

War-wounds have with each succeeding war been caused in increasing number by high explosives, missiles with more irregular form and with relatively slower speed; and in this present world war to a greater extent by secondary objects, as broken glass, wood, masonry, etc. All of this leads to greater traumatism, and increasing incidences of the two great complications of wounds, hemorrhage and infection.

From the past wars we learned, but did not always profit as we should from recorded experiences. Ambroise Paré taught that the wounds be left undisturbed: "I dressed it, and God healed it." John Hunter, in his treatise on "Gunshot Wounds," in 1761, remarked: "A part of the solids surrounding the wound is deadened and is afterwards thrown off as a slough." Larrey, Napoleon's great medical Director-General, who developed the plan on which all modern military

medical care is based, in 1797, emphasized the value of treatment at the earliest possible moment. We learned, therefore, from Paré the healing process of physiology; from Hunter the nature of the injury; and from Larrey the importance of time. In the last great war, the lessons learned were the rôle of devitalized tissue, the value of early wound excision and, to some extent, the importance of immobilization.

WOUNDS¹⁻⁵

The nature of the soft tissue wound is ragged in outline and follows an irregular course through or into the tissues. Since tissues vary in their structures, i.e., the strong continuity of the skin, the elasticity of the blood vessel walls, the cellular friability of muscle and the rigidity of bone, the damage done varies with the tissues struck. The skin tears, the blood vessel wall flexes to one side, the muscle ruptures and has a comparatively wider area of tissue destruction, and the bone shatters, giving a secondary larger explosive effect. Since the missile causing the wound is, as a rule, of blunt irregular type, and is traveling at a comparatively slow rate of speed, a contusing injury from the blast force occurs along all sides of the wound, resulting in a varying devitalization of neighborhood tissues. In addition the irregular-shaped missile, be it primary or secondary, is prone to carry in with it pieces of clothing or other worn objects, and dirt or the local terrain. These factors, therefore, lead to an irregular shaped wound, of irregular course through the tissues, a devitalization of neighborhood tissue and a bacterial contamination of the injured tissues.

WOUND CONTAMINATION AND INFECTION

The soiling of all wounds under war conditions forces us to consider wounds in their two main stages, that of contamination and that of infection. Contamination is that stage where the bacteria are upon the surface and not as yet proliferative; whereas infection is the stage where the bacteria have invaded the tissues and proliferation is occurring.

The stage of contamination may exist up to twelve hours, but preferably should be considered up to six or eight hours. The degree of contamination varies, dependent upon the terrain, a heavily-cultivated soil or a sandy desert; the condition of the weather giving a dry warm dust or a muddy contamination of objects and clothing; the portion of the body involved, for example, the clostridia are more common about the lower extremities, especially the thighs; and the type and cleanliness of the clothing worn and the cleanliness of the individual, for example, the clostridia are found in a high percentage of instances to be present in woollen garments, and recent bathing gives less infection, as was well illustrated in the Russo-Japanese War.

The stage of infection or invasion of the tissues follows that of contamination. It is dependent upon the pathogenicity and virulence of the in-

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From the Woodland Clinic, Woodland, California.

vading microorganism; upon the degree of local trauma, that is, the amount of devitalized tissue; the presence or absence of foreign material acting as a focus; and the resistance of the patient locally and constitutionally.

RÔLE OF DEVITALIZED TISSUE

The rôle of devitalized tissue in bacterial contamination and infection was emphasized during the last great war as it never was before. *The observance of this phenomenon is the most important aspect in the care of war wounds.* A vital tissue will resist infection in varying degrees, but a dead piece of tissue serves as an excellent medium upon which all types of microorganisms, especially the clostridia, thrive. A scalpel wound has only a microscopic injury to tissue, a machine gun or rifle bullet has a comparative high velocity, and a sharp and narrow striking force so causes little comparative tissue damage; but an irregular shell fragment has a slower velocity, a greater striking force, and causes wider tissue damage.

The foreign body acts mainly as a vehicle of infection, but plays an important part in sustaining the infection. Bits of clothing or contaminated terrain are the most evil, and serve as niduses of infection.

The patient's resistance, both local and general, has to be reckoned with the same as in peacetime surgery. The general resistance is lowered in instances of hemorrhage, exhaustion from physical fatigue or exposure or sepsis. The local resistance is obviously dependent upon the nourishment of the injured portion of the body and its blood supply. The greater the trauma there results a greater contusion of tissue, a greater amount of extravasated blood, a wider dispersion into the tissues of extraneous material, and a larger area deprived of an adequate blood supply. An impoverished blood supply leads to tissue of poor vitality, an ideal culture medium, and an easy invasion by bacteria.

BACTERIOLOGY⁶⁻¹⁸

The most common bacteria infecting wounds in the last great war were the spore-bearing anaerobes, *Clostridium tetani*, *Clostridium welchii* and *Clostridium septicum*, and the hemolytic streptococci.

Terrain and climatic conditions play an important part, and yet the severe traumatizing injuries of peacetime and research investigation demonstrate that the same pathogenic microorganisms are present everywhere, in our woolen clothes, in our school yards, on the walls of our buildings, in our yards, gardens, streets and highways, and in the instance of the hemolytic streptococci, especially in the nasopharynx of many that are well described as "carriers."

The invasion of the *Clostridium tetani* causing tetanus is well controlled by the use of tetanus toxoid prophylactically. This microorganism, as all pathogenic microorganisms, has its invasion enhanced by devitalization of tissue such as

occurs in war wounds; and since it is a spore bearer, it can lie dormant under certain conditions in pathological tissues. Therefore, when surgery in a fresh war wound, or a secondary operation in a previously traumatized wound, is to be done, further stimulation of antibodies should always be obtained by giving a further administration of toxoid.

We have now reached that state of knowledge where the use of tetanus toxoid should be recommended to certain individuals and type of workers, i.e., those persons suffering from some form of allergy, and those workers where contact with animal and human excretae is common.

Gas gangrene is an infrequent complication of certain anaerobic bacteria, especially *Clostridium welchii* and *Clostridium septicum*. Many of us were confronted with it for the first time in the last great war. In 1914, the incidence of gas gangrene amongst the British Expeditionary Force amounted to over 12 per cent of the number wounded, and of these 20-25 per cent died. By 1918, due to earlier treatment of the wounded and excision of devitalized tissue from the wound, the incidence had fallen to 1 per cent.

These anaerobic, spore-bearing bacteria are found in all tissues, but it is chiefly in muscle that we see their complication, gas gangrene, develop. Quist divides the clinical evidence of these causative organisms into three groups: "(1) harmless saprophytes in ulcers with no pathogenicity, (2) pathogenic microorganisms producing an infection of the cellular connective tissues; gas infection of a wound or anaerobic cellulitis, and, (3) as invaders of muscle—true gas gangrene." He bases his contentions upon reported observations of reliable authorities.

Many of us, as Alanson Weeks and myself, in World War I, observed the presence of these microorganisms in chest, knee-joint and brain war wounds without any clinical manifestations of disease.

The anaerobic cellulitis or local wound manifestation is seen in subcutaneous tissue. Here occurs some devitalization of tissue, hematoma and the bacteria proliferate. There may be some extension of the products of the gas-forming microorganism to give local swelling and crepitus to some distance from the abscess, but this form of the disease, while it can go on to more extensive involvement and toxemia, usually promptly subsides with adequate drainage and removal of pabulum on which the microorganism develops.

GAS GANGRENE

"Gas gangrene" is an acute, spreading gangrene with gas formation and muscle involvement. It is not the muscle involvement alone that is essential, but an additional factor of the greatest of importance is the confinement to limited space—*tension*. Large traumatic wounds have been seen with exposed masses of evident anaerobic infection, dead muscle, gas formation, musty and putrid smell, and positive smears and cultures of *Clostridium welchii*, and yet the patients, while

somewhat toxic, do not show the clinical characteristics of gas gangrene. The disturbance of the blood supply is the important antecedent to proliferation of the infection. If a foreign body with microorganisms penetrates through a small opening and grossly injures the muscle without disturbing the overlying fat, skin and fascia, there is present the ideal condition for their development—namely, devitalized tissue, freedom from oxygen and an enclosed area for increased local tension within constricting fascial tissues, so that blood supply can be impaired to point of destruction. As a result, one sees involvement of a single muscle or of a group of muscles or an extremity as a whole. Some muscles, as the gracilis, are believed to have a limited and terminal blood supply, and are especially prone to development of gas gangrene. Supporting the importance of the tension of tissues, the confinement of retroperitoneal tissues or hematomata, as in a hemothorax infected by gas forming anaerobes, has been observed and reported as giving rise to inevitable fatal toxemia spreading cellulitis and gangrene.

The destructive process in the muscle primarily increases intrafascial tension from gas and fluids, a strangulation of the blood supply by compression, and a probable injury to the blood vessel wall by the toxin, and a resulting degeneration of the muscle fibers. Blood stream invasion of the microorganisms in any dangerous degree is not thought to occur until there is an overwhelming local infection. In the terminal stage a severe toxemia occurs, and because of a hemolytic effect from the toxins a jaundice frequently occurs.

CLINICAL SYMPTOMS AND SIGNS OF GAS GANGRENE

The clinical symptoms and signs of gas gangrene are:

1. A painful wound.
2. Increased sensitiveness to the local tissue.
3. General malaise.
4. Restlessness to a degree of increased mental alertness maintained almost to the end of life.
5. Nausea and vomiting.
6. An increase of the pulse rate without corresponding increase in the temperature.
7. Swelling of a nonpitable tenseness and often palpable gas crepitations.
8. Musty or mouse-like smell to the tissues.
9. Thin, muddy, sero-sanguinous drainage, with or without bubbles of gas.
10. An Icteric tinge to the sclera and skin from hemolysis.
11. Muscle of a deteriorating nature even to complete dissolution.

The clinical symptoms and signs above noted are not absolutely diagnostic, for hemorrhage, shock, or marked debilitation, and a less dangerous wound infection, can stimulate its development. Air, left in an operative wound or from a lung and chest wall injury, with later palpable crepitus, is stimulating to some deep thinking. It is well to remember that, within twelve hours, a

severe infection can develop, and that a diagnosis is made, not upon clinical symptoms so much as upon physical examination of the wound area. Therefore, when gas gangrene is thought to be likely, two-to-four-hour examination should be made in the immediate postoperative or post-traumatic periods.

Bacteriological examination is confirmatory. X-ray evidence of gas is valuable in confirmation, but the presence of gas in the tissues without clinical evidence is not definitely diagnostic. Let it also be remembered that gas or air in tissues pass along tissue cleavage lines, between muscle and subcutaneous tissue, but more especially along the main blood vessels. The extent of gas has no relation to the extent of a possible gas gangrene; for example, in a calf-muscle group infection, gas crepitation has been palpated as high as the groin region in several instances.

TREATMENT OF GAS GANGRENE

Treatment must be instituted as early and promptly as possible; Eliason spoke well in saying, "the mortality is dependent on the promptness with which treatment is instituted." Surgery is the first and most dependable treatment, both from a prophylaxis standpoint or for cure. Surgery consists in a complete eradication of the devitalized tissues on which the microorganisms live and proliferate, and the eradication of tension on the deeper involved tissues. This means removal of one muscle, a group of muscles or possibly an amputation, as conditions indicate. The fascial planes must be split to prevent tension on the underlying tissues, muscle especially. Viable, pink, contractile bleeding muscle without tension argues well in eradication of the infection. At times, amputation through a joint may be wise. Strict attention to the avoidance of carrying the infection by instruments or sponging to another part must be given. Avoidance of the use of a tourniquet that may give higher traumatization is recommended. Not closing the wound and packing with some dry gauze, or gauze with some oxygen liberating solution, is best. Avoidance of any constricting dressing is necessary, and observation every two to four hours for extension or metastases needing additional care should be made.

Serotherapy has proved its value, and we speak from personal observation and experience as well as from authentic reports in medical literature. A polyvalent anaerobic antitoxin from *Clostridium welchii*, 10,000 units, and *Clostridium vibron septique*, 10,000 units, in the therapeutic dosage according to the clinical response, is of definite value, both, we believe, prophylactically as well as curative. We recommend that where gas gangrene is anticipated, a therapeutic dose of gas gangrene antitoxin be given as prophylaxis, and be so given as to provide a continued source of supply for absorption by the body, namely 50 per cent intramuscularly and 50 per cent subcutaneously. For treatment purposes it should be given in adequate dosage, for the reaction is on

a quantitative basis. The need of treatment is judged by the pulse rate and patients' reactions generally as well as by the local involvement. Some believe it of added value if injected locally near the wound; although theoretically, since it acts through the circulation, it would not seem to be of any material consequence.

X-ray therapy, on the basis of a stimulating generation of H_2O_2 in the tissues, has of recent years been strongly recommended by several American authorities. Williams and Hartzell locally reported, in 1939, of its value, and are convinced that it is specific. Kelly has been the leader in urging this form of therapy and has many supporters, especially amongst the radiologists. It does seem that in all convincingly-proven cases other therapy, as serum or surgery coincidentally, have been employed. Quist is of the opinion that many of the successful results treated by x-rays have been those of gas gangrene cellulitis, a localized affair under any circumstance. Mullaley, an authority on gas gangrene, but apparently without any basis of experience in this therapy, says: "As to x-ray, I would hesitate to use an empirical method in a disease so dangerous and rapid." Maes, from reports, recommends it be used as an adjunct in treatment and that, as a prophylaxis, its use is justified. Personally, we believe it still in the experimental stage, and that its use should be only as an adjunct to surgery primarily and serotherapy secondly.

Local chemotherapy to the wound, in the form of the sulfonamide group, is as yet in the trial stage, but may play a valuable part in eliminating pyogenesis that assists the activity of the anaerobes in a symbiotic manner.

Treatment, therefore, should be prompt, surgery primarily; serotherapy prophylactically and for treatment, but x-ray therapy may be of value and the sulfonamides are worthy of trial.

STREPTOCOCCUS INFECTION

The streptococcus hemolyticus was the third and most common type, and most persisting type of wound infection in the last great war, and appears to be equally as common in this present world war.

Colonel Colebrook estimates that 70 per cent of all deaths due to infection of war wounds are caused by streptococci. Fleming and Porteus say that hemolytic streptococci were "responsible for almost all the severe septic complications of these 'war wounds' and found them in 90 per cent of all cases of compound fracture of the femur of 1 week old, and in all undebrided wounds of three to four days. Weinberg and Squire reported, in 1917, that streptococci were found in 36 of 91 war wounds; and of 49 per cent positive blood cultures, 44 were hemolytic streptococci.

Fifteen per cent of all wounds culture streptococci in the first 12 hours, while in a few days the percentage is much larger—90 per cent. Meleney, from a study of peacetime acute trau-

matic wounds, finds in 200 such wounds bacteria present in every instance, and no one can tell which wound will develop an infection, and that hemolytic streptococci were present in the stage of contamination in 17 per cent of instances.

The source of this infection is from the soil, from the contaminated soiled clothing, and from the unapparent slips of technique in wound dressings, and from the nasopharynx of individuals in contact with the wound. Hare stresses the last source especially, states 7 per cent of normal people are nasopharyngeal carriers of the important strain—hemolytic streptococcus pyogenes, (streptococcus pyogenes of Rosenbach); and that in the last war a wounded man, in his transfer from the regimental aid station to the casualty-clearing station or evacuation hospital, came in contact with 333 people, and often had his wound dressed three to four times before corrective treatment was carried out.

The incidence of this comparatively common infection is reduced by the removal of the contaminated and devitalized tissues and foreign material as early as possible in the stage of contamination, and the leaving of the dressing undisturbed so as to avoid reinfection from exogenous sources.

LOCAL USE OF SULFONAMIDES

There is, today, a further procedure that the majority of reports recommend as having an inhibitory effect upon the streptococci proliferation—the use of the sulfonamides locally.

The sulfonamides are believed to have a definite action locally, and to not interfere with tissue healing. Sulfanilamide is the more popular form, since it has greater solubility, endures for two to three days, does not tend to "crust" or "cake," and does not have the occasional *sensitive* reaction seen with sulfathiazole. Their action is believed to be bacteriostatic in a manner of affecting the nutritive substances—a starving of the streptococci. Their most dramatic effect is in acute infections, reported as most effective in superficial open wounds as from third degree burns; of little or no value in abscess formation, and of definite value in wounds in the period of contamination awaiting debridement. It is estimated that, used in a preoperative prophylactic manner, a "lag period" of proliferation of bacteria of 5 to 6 hours is obtained. Therefore, application of the sulfanilamide early and post-operatively in the wound is recommended, also that it be employed in a powder form and sprayed by a powder insufflator into all the wound recesses whenever used.

TREATMENT 19-25

Since the rôle of devitalized tissue is the most important aspect of war wounds, it follows that the treatment of this tissue is the most important aspect of war surgery. The modern proper treatment of this tissue is to remove it completely, together with any foreign material or débris at

the earliest possible moment always in the "stage of contamination." In the American, and to a large extent in the English literature, we speak of this procedure as *debridement*.

DEBRIDEMENT

Debridement is a word taken over from the French language and anglicized, and has become, because of common usage in the English language, to mean the meticulous excision of all devitalized tissue and removal of all foreign material from a wound. There are, however, many outstanding scholars in our medical fraternity, especially in England, who decry the usage of the word as we employ it, and steadfastly refuse to accept it except in the strict translation from the French language, to wit: incision, drainage and removal of *débris* only. It is a word first used by Desault in 1789, later in 1812 was employed much by Larrey, and was, in its original sense, the treatment used in the last war up to approximately 1918, when we Americans began our participation. By careless translation, therefore, the word has come to mean the meticulous excision of devitalized tissue and removal of *débris* resulting from any traumatizing or necrosing force. It has even a new associated verb *debride*, and adjective *debrided* and *undebrided*. The French speak of the same procedure as "epluchage." The Germans employ the term "surgical revision" or "wound revision," to mean the same. Care, therefore, in the reading of authoritative articles on war surgery must be given to the interpretation which the author in each instance gives it. For example, Trueta regards debridement as a procedure to obtain drainage. Bailey, an English surgeon, in his excellent text on "Modern War Surgery," (1941) urges the strict interpretation of the word. Ogilvie, (1938 and 1940) on the other hand, believes language is a "living thing" and uses the word in the larger sense. American authors as a whole use it in the larger sense. Personally, I am in favor of retention of the word with its fully acquired connotation; for, by common use, it has acquired a definite meaning to the majority, and carries much history.

The procedure of debridement was first suggested in 1897 by Friedrich, a German surgeon, who published some results of experimental work on excision of contused wounds, and advised they be treated as if they were neoplasms. It was not until 1918 when Gray, of Aberdeen, in the British Army, DePage of the Belgian Army and Lemaître of the French Army first called attention to the importance of the meticulous removal of all devitalized tissue and *débris*. It was first known to us as the "abortive treatment," and was recommended in the preinflammatory period. Later, because it was so routinely done at the Evacuation Hospital, it obtained the name of "Evacuation Hospital Operation."

OTHER PROCEDURES

"Judgment is the prime requisite." Gentleness

in handling of tissues and meticulous thoroughness of the removal of all devitalized tissue and foreign material and care to hemostasis, is the second requisite. Originally, curved scissors were, and still, in the deeper wound recesses, are the cutting instrument preferred. However, if knife-blade severance into live tissue can be made, it is better. Sponging should be of the blotting, not wiping type. Flex and extend the extremity in order to reproduce the exact position when the wound was caused, and the path of the missile will be more easily followed. The skin is treated as conservatively as possible, but opened sufficiently always in the longitudinal, not transverse direction, to adequately expose all pockets and recesses and devitalized tissue. The subcutaneous tissue needs removal of only the contaminated tissue. Fascial planes must be given special attention to prevent postoperative, valve-like action, (Pirogoff's Pouch), and thereby free drainage; therefore elliptical excision, or adequate transverse incision of 1 to 2 cms., should be done. The most important tissue, the muscle, is now attacked and the meticulous care to this layer above all other spells success or failure. All muscle, lacking the normal red-to-pink color, failure to contract when pinched, or to bleed when cut, is excised to the point of absolute vitality. Trueta put it briefly and strongly when he said: "To be conservative with the limb is to be radical with the tissues," and we add especially muscle. Bone loose, and devoid of blood supply, should be removed. Soiled bone should be rongeur'd away or at least cleansed with some antiseptic, and ether, an excellent fat solvent, we like best. Thorough search for bone fragments, driven to some distance from the path of the missile, is necessary. All foreign material is, of course, removed. It becomes apparent, therefore, that, previous to doing a debridement, a careful history of conditions of the injury, the position of the extremity, the material traversed by the missile, and a careful physical examination of circulatory, nerve and muscle function, are important. An x-ray plate is always wise. One must never forget that a hematoma or blood clot can serve equally well, as devitalized muscle, as a nidus of infection and so, lastly, careful attention must be given to hemostasis.

In war wounds under active military engagement, primary closure, except in certain specified areas of the body, cannot be safely done. Therefore, consideration of dressing is necessary. Many types of dressings have been tried. In the last great war, General J. M. T. Finney of our army, found, from a questionnaire to the American base hospitals, that the majority found wounds dressed with plain gauze were in the best condition. Trueta, from his experiences in the Catalonian Hospitals, preferred sterile dry gauze. Our observation was that dry sterile gauze was as good as any type of dressing, although the proliferative granulation tissue in the wound-healing tended to grow into its meshes. However, a retrospective view

of the wound care, with consideration of the excellent reports of Trueta and others in the Spanish Revolutionary War and the English surgeons in the present world war lead me to believe it was because wounds so dressed were less frequently disturbed than the wounds dressed with chemically-impregnated gauze.

REST²⁶⁻³¹

This has already brought a valuable lesson. John Hilton, in 1863, and Hugh Owen Thomas, father of our modern Thomas traction splint, in 1880, emphasized the importance of rest to healing tissues.

H. Winnett Orr of Lincoln, Nebraska, carried this a step further to absolute rest and noninterference with wounds involving compound fractures. Trueta, of Barcelona, and others associated with him, next added to our knowledge, and their results are now substantiated by others of experience. One should digest Trueta's reports, especially that small text written by him, "Treatment of War Wounds and Fractures," published in 1939. He primarily and rigidly did a debridement, packed the wound with dry gauze and then, if satisfied that infection had been adequately eliminated, applied, except for protection to bony points, a skin-tight plaster cast. In the lower extremity, because of the greater danger of infection, he might wait two to three days before applying a cast. He reasoned that movement increases the dissemination of infection and absorption of toxins due to interference with local defense mechanisms, through rupture of small capillary and lymphatic thrombi, by which the wound is isolated from the general circulation. With such care he reported 1073 cases of compound wounds with only .75 per cent of true clinical infection demanding removal of the cast. He also did change the cast from time to time. The greatest criticism has been that of the odor associated with the wounds so treated. Rudolph Matas, our most respected surgeon of New Orleans, was stimulated to make such criticism but after personal inspection of the excellent results, declared, "But when I saw them get well, with their wounds healed, I realized that 'not all cheese that smells bad is bad!'"

CONTINUITY OF CARE³²

Lastly, we wish to call to your attention an important lesson fortunately learned early by the American medical forces in the last war—the advisability of the surgeons following their own cases into the wards for the postoperative care. The need of this became apparent to many, as it did to Weeks and myself, for only the surgeon can know well what to anticipate. Robert Jones emphasized that "the principle of continuity of treatment and of surgical responsibility cannot be over estimated." Hart, in the present war, stresses this point and says, "with the surgery, the surgeon's essential task is only half over."

SUMMARY

1. Soft tissue wounds under war conditions have a more widely-distributed tissue injury.
2. It is well to consider these wounds in the two stages: the stage of contamination 6-8 hours and the stage of infection.
3. The types of infection and their treatment have been discussed.
4. The rôle of devitalized tissue in bacterial contamination and infection is the most important aspect of war wounds.
5. Debridement—the meticulous excision of devitalized tissue and removal of débris—is the most important aspect of treatment of war wounds, and should be done in the stage of contamination.
6. Absolute rest of the injured parts and infrequent dressings of wounds, are lessons of importance learned in this world war, and should be added to debridement.
7. Continuity of care by the original surgeon is most advisable.

Woodland Clinic.

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SOME CONSIDERATIONS REGARDING THE ETIOLOGY OF IMPETIGO CONTAGIOSA*

HENRY SUTHERLAND CAMPBELL, M.D.

Los Angeles

BECAUSE the time allotted for presenting papers has been curtailed during this year's meeting to two half-days, I shall limit my address to ten minutes. This is not a formal paper, but rather a consideration of certain views long entertained regarding a most controversial question, i.e., the etiology of impetigo contagiosa. That the present warrants its consideration is found in an observation in the *Lancet* (2:275:41) in which Cruickshanks states that the disease, trivial in itself, can account for a fair percentage of invalidity among troops in wartime. In a recent discussion of a paper by Epstein on this subject, Sulzberger observed that he was not so certain that the fulfillment of Koch's postulates sufficed to prove the etiologic rôle of an agent in the case of skin inoculations, as he believed that one could reproduce the lesions of impetigo contagiosa with any one of several microorganisms isolated from a lesion of impetigo contagiosa because the other microorganisms were already present on the skin. I believe this observation would have been received with less enthusiasm than criticism but a few years ago. On reading it

I felt gratified; because, at long last, certain pre-conceived notions of mine were receiving a small modicum of support. I recall an early mentor dismissing my suggestion, of a filterable virus as being a probable cause of impetigo contagiosa with an expressive latin shrug that indicated I had in no small measure committed Lesé majesty; but this was at a time when extensive research in both Germany and France had shortly been concluded, and when that comfortable goal of type-classification and etiological proof had in general been reached. Epstein's paper corroborates these findings, and he reproduced the lesions of impetigo contagiosa from a pure culture of *Staphylococcus Pyogenus Aureus*. The subcultures, while yielding regularly the original strain in pure culture, were not apparently used in further inoculation experiments.

INFECTION OR CONTAGION

The conviction, that we were dealing with some agent other than staphylococci or streptococci, came many years ago during an epidemic of impetigo contagiosa in a nursery ward, its spread, in the face of the most elaborate and rigorous quarantine measures, being so uncanny that one eventually wondered whether we were not dealing with an infectious process proper rather than a contagious one. At a later date it appeared the long incubation period, in some cases up to twelve days, might explain the apparent inefficacy of quarantine methods instituted following the appearance of the disease.

Although impetigo contagiosa frequently follows injuries, it sometimes occurs on apparently intact skin. However it may be occasioned, certain phenomena regularly obtain. For a longer or shorter period of time following its appearance, it has a tendency to spread irrespective of therapy. While there are modifications in the tonality of impetigo contagiosa, the lesions are of such typical appearance as to be distinctive, and can be readily distinguished. On involuting, the lesions heal without leaving any scar.

It is difficult, in the light of the above, to believe these phenomena to be due to staphylococci, streptococci or to both. For we know these organisms to be ubiquitous in the skin, yet in no other skin infection where these organisms are found can a prognosis of the course and the resulting damage be made. And in no other infection of the body, where staphylococci and streptococci are commonly found, do similar changes occur.

A FILTERABLE VIRUS?

Now, if one premises a filterable virus as being the etiological agent in the production of impetigo contagiosa, all the phenomena referred to become possible of acceptancy. For the minor clinical variations could be explained as being due to the symbiotic action of the type of secondary organism dominant in the lesion, and it would seem that this is what has already been proven. Furthermore, assuming the theory to be correct, any

* Chairman's address. Read before the Section on Dermatology and Syphilology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

primary pure culture of staphylococci or streptococci would be so intimately associated with the virus, that it would be present in sufficient strength to reproduce the disease. It is doubtful, however, if pin-point subcultures would carry the virus over in reproductive strength.

We have, for several years past, carried on intermittent experiments, at widely-spaced intervals, based upon the acceptancy of the above premise, and we can state that on two occasions we have produced lesions of impetigo contagiosa on our arm using primary cultures of staphylococci. In neither could we produce lesions with the subcultures. The most depressing finding, however, was the fact that on several occasions we have been unable to reproduce the disease with material taken direct from freshly-denuded lesions which had not been previously treated. We were thus persuaded that regional as well as soil factors play no small part in the reproduction of the disease, and we believe other factors obtain. Certain is it that it is not as contagious as one has been led to believe; and although the frequent involvement of the face suggests a regional sensitivity, one's daily practice makes of necessity a covered area the region of choice for inoculation.

AUTHOR'S EXPERIMENTS

Our main efforts, however, have been in the direction of attempting to reproduce lesions of impetigo contagiosa with Berkfeldt filtrates of washings or swabbings taken from active lesions of the disease. In these experiments our greatest drawback has been in finding cases with unmediated lesions. On Monday, March 16, 1942, a bedpatient at Olive View Sanatorium was brought to the clinic with an untreated vesicular type of impetigo contagiosa. The lesions were washed with some five c.c. of sterile water, by means of a sterile swab, into a sterile test tube. This was then passed through a Berkfeldt filter and, following a simple face-wash, several loopfuls of the filtrate were smeared over my entire face. The forearm was also lightly scarified with it. Some four days later my face developed several scattered itching points and these later showed a few discrete erythematous lesions. They were evidently finely vesicular, as the roofs were removed by my razor, leaving tiny rounded bleeding points. The following, or 6th day, I felt convinced I had developed impetigo contagiosa. As it is somewhat difficult to make a diagnosis on one's self and, in order to convince myself that it was not the result of wishful thinking, I went to Dr. Saul Robinson, who examined me and pronounced the condition one of impetigo contagiosa. It was not of stubborn character, however; and after an initial spread, it subsided within a week under therapy with hydrargyrum chloridum corrosivum, in bay rum. Approximately one cubic centimeter of the filtrate was given to the laboratory of Doctors Zeile[†], Maner and Hammack, and this was planted in glucose agar broth. On the

fifth day following the culturing, they reported the filtrate to be sterile.

No extra care was taken in cleansing the face previous to applying the filtrate, neither were any cultures taken from the skin of the face in this instance. This was due to the fact that we had done the same thing so often before, with negative results as regards reproducing the disease, that we did not think it worth while, as nothing was anticipated on this occasion.

SUMMARY

Let us emphasize, in concluding, that this brief recapitulation is not offered as proof that impetigo contagiosa is due to a filterable virus, but rather in the hope that many others might perform this simple experiment with a view to corroborating or refuting this premise at some future date.

1930 Wilshire Boulevard.

FRACTURES OF THE FACIAL BONES: THEIR TREATMENT*

RULON S. TILLOTSON, M. D.
Sacramento

THE increased frequency of serious injury of the facial bones, due largely to automobile accidents, has stimulated interest in the treatment of this group of fractures. The tendency is to regard these injuries as lying in the field of general surgery; however, orbit, eye, nose and sinus complications give them a particular interest in our field of practice.

DIAGNOSIS

Fractures of the facial bones may be divided into recent and old bony injuries. Recent fractures often require study in determining their character and extent; old fractures are evidenced largely by the presence of contour defects.

With any injury of consequence to the soft tissues of the face, injury of the bony structure should be suspected. A routine order of inspection and palpation will help to avoid overlooking such damage. The following order is suggested: the orbital rims, the malar attachments and zygoma, the bony arch of the nose, and, last, the jaws, with attention to their mobility and dental occlusion. Extensive soft tissue injury and swelling may interfere with accurate palpation. Emphysema of the soft tissues occasionally is seen, particularly in fractures involving the medial wall of the orbit or the anterior wall of the antrum.

A neurologic survey should be made to include the vision and pupillary reactions, as well as the hearing. Any sensory or motor impairment of the facial area must not be overlooked.

X-rays are essential, and special positions are often required to show the necessary detail for diagnosis. When available, laminagraphic exami-

*Read before the Section on Eye, Ear, Nose and Throat, at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.



Fig. 1a.—Immobilization following nasal fracture. The molded copper splint. Pattern of splint below—14 ounce rolled annealed copper. See also diagram Fig. 1 (c).



Fig. 1b.—Immobilization following nasal fracture. The plaster splint.

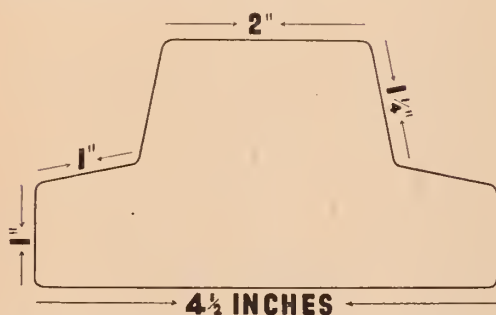


Fig. 1c.—Diagram of copper splint. Dimensions are approximate. May be cut to fit. See also Fig. 1a.

nation, as described by Moore and Cone,¹ may offer advantages in diagnosing fractures of the ethmoid area, and in better outlining temporo-mandibular joint structures.

GENERAL CONSIDERATIONS IN TREATMENT

Severe facial injuries, particularly of the upper one-half of the face, are frequently associated with shock, skull fracture, or intracranial hemorrhage. These more critical complications should receive first consideration in treatment; however, some attention to the facial injury can usually be given at an early date. Fractures of the bony structures of the face, when associated with extensive injury of the overlying soft tissues, should be reduced first, and the soft tissue wound closed afterwards.

With multiple fractures of the face involving the nose, the upper jaw and the malar bones, reduction of the jaw fracture, and restoration of the orbital margins, should be carried out before the nasal deformity is corrected. The nasal arch and the septum depend largely on this part of

the facial framework for their support.

TREATMENT OF SPECIAL REGIONS THE NOSE:

The nasal bones are involved the most frequently in fractures of the facial bones. In the simple depressed fracture of one nasal bone, treatment consists of internal manipulation of the fragment to its normal position, and pack sufficient to keep it there.

In most nasal fractures, the nasal bones, the frontal processes of the maxillae, and the nasal septum are jointly involved in the fracture injury. Depending on the direction of the force applied, the bony arch of the nose may be deviated laterally, or depressed, or a combination of these deformities may result. Varying degrees of comminution of the fracture fragments may be present.

In fractures where the entire bony arch is deviated to the side with overriding of fragments, the fragments must be disengaged and lifted from within with a suitable elevator. After centering the nose by digital manipulation, a copper molded splint, as described by Salinger,² or a plaster splint, should be applied for maintenance of fixation. The splint should be left on for ten days to prevent any tendency to displacement of fragments or spreading of the nasal bridge (Fig. 1).

In severe depressed nasal fractures where there is usually considerable comminution of the nasal bones along with septal fracture, it is necessary not only to elevate the nasal bones,

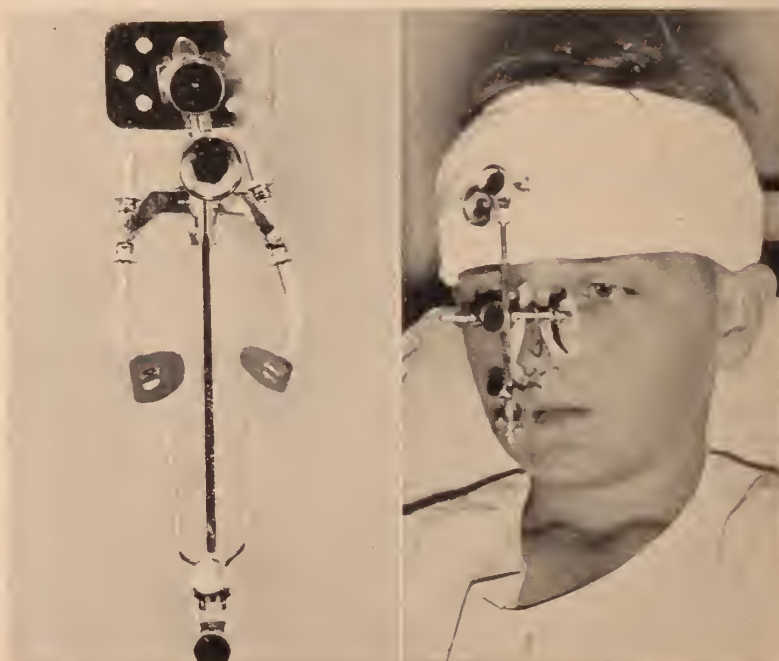


Fig. 2a.—Immobilization following reduction of depressed comminuted nasal fracture.

Fig. 2b.—Details of Straith splint assembly.

but also to provide some form of fixation to hold them in position. In addition to holding the bones forward, lateral pressure must be secured to retain a narrow contour of the nasal bridge. A splint assembly, such as the Straith, combines adequately the necessary mechanical requirements for the treatment of this type of fracture. In using this splint, a plaster head cast is applied, in which is anchored a rod running parallel with the nasal bridge. Two arms attached to this rod pass up into the nasal passages and can be elevated as desired. A second attachment includes two metal pads which can be regulated for any degree of lateral pressure required (Fig. 2). If the septum is fractured, rolled dental wax introduced into the nasal passages assists in its immobilization.

In considering old bony injuries of the nose, a

create room when the nose is replaced to the midline. Removal of an associated nasal hump, or shortening of the nasal tip, may be done in the course of the operative procedure (Fig. 3).

In old nasal fractures with a depression of the dorsum, also in bony defects of the forehead and orbital rim, cartilage and bone grafts may be used for contour restoration.

THE MALAR BONE:

The malar bone forms a prominent part of the face, coming next to the nasal bones in frequency of involvement in fractures. As it forms a part of the bony walls of both the orbit and the antrum, fractures of this bone with its lines of extension constitute an important, and often a serious and disfiguring type of fracture. If there is enough displacement, damage to the eye or its appendages may occur. Displacement of the globe with diplopia may result from depression of the orbital floor or from orbital hemorrhage.

If there is no comminution of the fractured malar bone, a stout steel hook, as the Langenbeck hook, introduced under the fragment through a small incision in the skin, may be used to elevate the bone into position. Displacement of the fragment is generally downward and backward, and the elevation is applied in the reverse direction for reduction. Hemorrhage into the antrum from tearing of the vessels of the periosteum often occurs in these fractures. This hemorrhage is absorbed often after a few weeks, and irrigation is unnecessary unless infection occurs.

In a malar fracture with a marked separation at the junction with the zygomatic process of the frontal, Gill's³ method of wiring with heavy silver wire, through drill holes made through the fragments, is effective in maintaining fixation. Stainless steel wire is considered more satisfactory by some surgeons, for its strength and lack of tendency to corrode.

If there is extensive comminution of the fractured malar bone, reduction is accomplished best by opening the antrum through the Caldwell-Luc approach. By application of pressure within the antrum, the fragments usually can be manipulated to their correct position. The antrum is packed firmly and an opening is made under the inferior turbinate for drainage, and the buccal incision is closed. The packing should be left in for ten days or more.

In this latter group of malar fractures, usually in cases not receiving adequate early treatment,



Fig. 3a.—Old nasal fracture. The twisted nose. Before correction.

Fig. 3b.—After correction. Removal of nasal hump, submucous resection of nasal septum and refracture and reposition of nasal bones.

common type is the so-called twisted nose. This type is usually the result of an old, untreated fracture, and shows the nasal tip off the median line with a lateral displacement of the nasal bridge. The septum is deviated with a frequent dislocation of its free border. The treatment is, in brief, a submucous resection of the nasal septum, followed with refracture and reposition of the nasal bones. Except in minor deviations of the bony bridge, it is necessary to excise a triangular piece of bone from the concave side to

the floor of the orbit may be damaged so severely that the eyeball has dropped down several millimeters from lack of support. An autogenous cartilage graft or a refrigerated cartilage isograft, as described by O'Connor,⁴ introduced subperiosteally along the floor of the orbit, may be used as a wedge to elevate the eyeball to its normal position (Fig. 4). Entire correction is not always obtained.



Fig. 4a.—Old orbital fracture. Downward displacement of eyeball from damage to orbital floor.



Fig. 4b.—Elevation of eyeball following introduction of cartilage graft in floor of orbit, refrigerated cartilage isograft used.

THE FRONTAL BONE:

The frontal bone, strictly speaking, is a part of the skull and not the face. However, as it forms an important part of the bony wall of the orbit and contains the frontal sinus, the treatment of its fractures may be considered properly in this discussion. In fractures of the anterior wall of the frontal sinus, depressed fragments are elevated and the overlying soft tissues closed. Usually external drainage is not necessary, and any hemorrhage into the sinus will be handled by absorption and drainage through the nasofrontal duct. If the posterior wall of the sinus is fractured, it is necessary to provide external drainage in order to avoid accumulation of discharge under pressure and possible intracranial complications. Occasionally, penetrating wounds of the orbit involve the thin and brittle orbital portion of the bone (Fig. 5).

THE ETHMOID AND SPHENOID:

In fractures involving the ethmoid sinus, emphysema of the orbital tissues is common. Meningitis may occur if the cribriform plate is involved. Drainage of cerebrospinal fluid from the nose comes from the cribriform plate area, and is generally a bad prognostic sign.

Fractures involving the sphenoid sinus are serious, due to their proximity to vital intracranial structures. The treatment of fractures involving both the ethmoid and sphenoid sinuses should be conservative, keeping the nasal passages as free from infection as possible, and advising against forcible blowing of the nose, to prevent emphysema of the surrounding soft tissues.

Sudden loss of vision may occur in fractures through the optic foramen from direct nerve injury or hemorrhage into the sheath of the nerve.

Fracture or displacement of the anterior clinoid process, as suggested by Horner,⁵ may produce optic nerve injury and blindness.

THE MAXILLA

Fractures of the maxilla and mandible are treated best in coöperation with the oral surgeon; however, general principles employed in the treatment of these fractures should be understood by anyone treating facial injuries.

In unilateral fractures of the maxilla, the commonest type is the fracture that extends obliquely or horizontally above the teeth and continues down near the midline of the hard palate. These fractures, in many cases, can be reduced by pushing the fragment back into place, the fixation maintained by wiring the teeth on the sound side of the maxilla to those of the mandible. Soft brass wire, twenty-four gauge, or stainless steel wire, may be used as ligatures in fastening opposing teeth. If several teeth are absent, a heavy, German silver, one-half round arch wire may be

fastened to the labial surfaces of the upper and lower teeth. These two heavy wires are then attached together for fixation.

In bilateral fractures of the maxilla, the commonest fracture is the transverse type, as seen in steering-post injuries and guest passenger injuries as described by Straith.⁶ In these cases, the entire upper jaw is pushed backward freeing it from the rest of the skull. The jaw usually sags down posteriorly, so that the upper teeth are posterior to the lower, giving the so-called open bite type of deformity which makes mastication impossible. Reduction and immobilization in these fractures are obtained by means of a head apparatus and a reversed Kingsley splint. This splint consists of a heavy metal arch bar wired to the outside of the teeth. The arms of the splint are fastened to this bar and extend out of the mouth on each side for attachment to a plaster head cast. Straps which can be shortened gradually, or heavy elastic bands, run between the arms of the splint and cast.

With this apparatus, the jaw is reduced by degrees. After several days, when the upper and lower teeth have regained occlusion, the jaws can be wired together until complete union has taken place (Fig. 6).

THE MANDIBLE:

In the great majority of fractures of the mandible, no matter where situated, adequate fixation can be maintained by wiring the teeth of the maxilla to those of the mandible. In edentulous patients, in certain types of mandibular fractures, direct wiring of the bony fragments may be employed. Kazanjian⁷ recommends exposure of the bone ends through the oral cavity as an easier and less traumatizing method than through the



Fig. 5.—Fracture of orbital portion of frontal bone due to penetration of piece of windshield. Uneventful recovery followed removal through brow and orbital approach.

external approach. In fractures behind the third molar tooth, the posterior fragment is pulled upward and forward, and a special method of reduction is required. The following procedure is efficient for reducing the displaced posterior fragment. A head cast is applied in which is incorporated a wire hook that emerges in the mastoid region on the involved side. A wire is passed through the fragment and a rubber band, stretched from this wire to the hook, gradually pulls the posterior fragment back into position.

In fractures of the neck of the condyle, where the head is driven out of the socket medially, an

effort may be made to push the condyle back in the socket; however, any open operative procedure to adjust the fractured ends in position is not advisable.

SUMMARY

In all injuries of the face, fractures of one or more facial bones should be suspected. Early reduction and fixation are imperative. Fractures of the malar bone and zygomatic arch are often serious and disfiguring. The treatment of these fractures must be individualized, depending on the location and degree of displacement of the fragments. For severe depressed fractures of the nose, and for certain bony injuries of both the upper and lower jaw, a head cast and special retaining appliances may be necessary for maintaining fixation. In old fractures of the face, transplants of bone and cartilage may be used in correcting contour defects.

1127 11th Street.

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Fig. 6.—Immobilization following bilateral maxillary fracture. Details of reversed Kingsley splint below.

CLINICAL NOTES AND CASE REPORTS

MYXO-SARCOMA OF THE SKIN*

REPORT OF CASE

MERLIN T.-R. MAYNARD, M.D.
San Jose

MUCINOUS degeneration of the skin is unusual, and a true sarcoma of this type springing from the collagen of the corium is apparently extremely rare.

REPORT OF CASE

The patient in this particular instance was a woman of 63, who had a sclerodermatous change in both cheeks of one year's duration. Three weeks prior to being seen, she noticed what seemed to be a small hole in the skin, as she described it, and she picked at it with a needle. A growth appeared shortly afterwards, which developed rapidly. No treatment had been applied except hot applications. A past history was negative of any significant factors relative to the tumor formation in the area of the jaw, except that she had spent a good part of her life on a hay ranch.



Fig. 1.—Photograph of the patient showing the lesion on the right cheek following the taking of the biopsy.

An examination of the patient showed a rounded, irregular tumor of the center of the right cheek where the

overlying skin was intact but very thin. The surrounding skin was firm, slightly scaly, and whitish in color. The left cheek showed similar skin changes, but no tumor growth. The rounded skin of the tumor felt fluctuant to the touch, and had a slightly bluish and translucent appearance. A biopsy was taken from the surrounding skin, and a large needle inserted into the soft area and

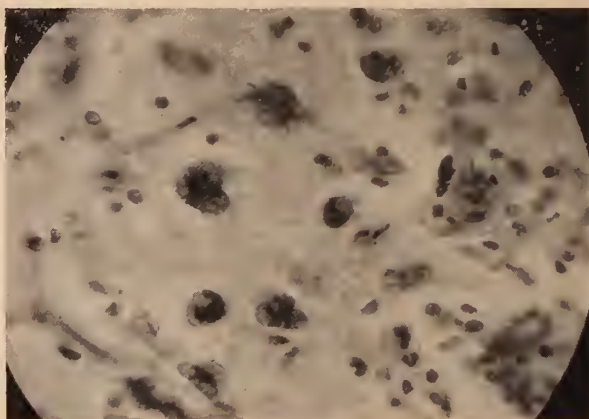


Fig. 2.—Photo-micrograph of the tissue removed at operation showing the myxomatous structure.

a withdrawal of fluid attempted. This failed; but as the needle was withdrawn, a clear mucinous string followed it. A section was then clipped out for a biopsy, following which the contents of the growth partially extruded but did not flow, remaining tissue-like in consistency. A dressing was applied.

The woman returned five days later, at which time the mucoid tissue had increased in quantity and was forcing the wound more widely open. It was decided to start modified Coutard x-ray therapy while awaiting the biopsy sections. The biopsy specimen when received showed the dermatitis of the surrounding area to be scleroderma. The biopsy of the lesion showed a myxo-sarcoma, involving the fibrous tissue of the corium.

Coutard therapy was continued for a total of nine treatments, at which time 1850 r. had been given. During this time the tissue seemed to continue its rapid growth, so that a surgical consultation was arranged and the entire area including the parotid gland and duct was removed. This was done because it was believed by the surgeon to be a mixed tumor of the parotid. The pathologists report follows.

Gross Specimen.—Consists of an oval elliptical-shaped piece of skin, 7 x 5 cms. in size. Centrally, is a slightly elevated dark lesion 2.5 cms. in width and centrally the skin is ulcerated. Upon cut section is an oval, poorly encapsulated nodule, 2.5 x 1.8 cms. soft, semi-mucinous, grayish-white in color. It extends to the underlying fascia, but apparently does not invade it.

Consists of fibro-areolar tissue containing two small grayish-white, soft lymph nodes, measuring up to 0.8 cm. in width.

Histological Examination.—One section is taken so as to show tumor which is situated between overlying skin on one side and Stenson's duct on the other. The tumor is partially separated from the latter by a narrow zone of fibrous tissue; apparently there is no relationship. The tumor is composed of rather widely-spaced, stellate and spindle-shaped tumor cells; they are separated from one another by considerable edema, and in places a homogeneous substance suggestive of mucin. Some of the nuclei are large, balloon-shaped, finely granular, and deeply staining. These changes, apparently, are secondary to and in response to irradiation. No definite mitotic figures

* Read before the Section on Dermatology and Syphilology, at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

can be found at the present time. In places, the stroma contains thin-walled, dilated capillaries, and is infiltrated by occasional tiny groups of lymphocytes. It is my opinion that this neoplasm did not have its origin in the salivary glandular system, but rather is a tumor which has had its origin from fibro-areolar tissue, arising possibly from either the corium or the subcutaneous tissue.

The section through a lymph node, embedded in adjacent fibrous tissue, shows a moderate lymphoid hyperplasia but no tumor. The diagnosis is: Sarcoma, Skin, Parotid region, Myxomatous.

COMMENT

The origin was undoubtedly mesodermal, springing from the collagenous tissue of the corium in an area of scleroderma. Its first appearance while very small in the skin surface is reasonable evidence of an origin in the more superficial collagenous layers.

241 E. Santa Clara Street.

TROPICAL RAT MITE INFESTATION

HIRAM D. NEWTON, M. D.

San Diego

A MOST interesting, and to me unusual, situation has recently come to my attention, which I consider worth the attention of all doctors in the southwest.

REPORT OF CASE

Mrs. C. A. J., age 39, consulted me in my office on April 21, 1942, complaining of a pruritic dermatitis of some weeks' duration. On inspection, I found various scattered pruritic papules suggestive of flea bites. She insisted that they were not flea bites, but that certain minute creatures crawled upon her, and that when they stopped, they bit her.

Fearing a case of acarophobia, I asked that she obtain some of these creatures for my observation. On the next day she appeared with a vial of small objects which, with a magnifying glass, appeared to be the size of the ordinary crab-louse (*pediculi pubis*). However, they were more elongated and slightly smaller than this creature. Moreover, the bites were more about the waist, legs and trunk, than about the pubis. No lice or ova were visible on the pubic areas.

The specimens were given to Dr. R. D. Harwood, Entomologist of the San Diego State College, and he submitted the following report:

"Although they were all immature, the mites from Mrs. J. are unquestionably the tropical rat flea (*Liponyssus bacoti*). This mite has only recently been introduced, but has become widespread. Both nymphs and adults have the annoying habit of leaving their hosts and traveling about when they will attack man if given the opportunity. If food, i.e., rats and humans can be withheld for two weeks, the mites will perish. If the rats are exterminated they may be especially annoying to man for a little while as they are out for blood. It may be necessary to spray floors, etc., if bad. I hope that this gives you the desired information."

COMMENT

Further inquiry developed the following facts: There were rats in the house. The husband and infant child had no apparent bites and search disclosed no mites on them.

Destruction of the rats, abundant use of flea

powder about the floors, and the use of pyrethrum ointment on the patient, eventually controlled the situation.

Interviews with persons engaged in rat extermination disclose that they are familiar with this mite, having at times resorted to cyanide fumigation of large buildings to control the infestation.

SUMMARY

Lesions having the characteristics of urticaria of external origin (bites), may be caused by the tropical rat flea.

The question arises as to possible danger of this pest, acting as a vector for some rat-borne disease.

1203 Bank of America Bldg.

Improved Design May Make Cars and Planes Safer

A mechanical analysis of seven cases in which human beings survived free falls from heights of fifty to one hundred and fifty feet leads Hugh DeHaven, of the Department of Physiology, Cornell University Medical College, New York, to declare in the current issue of *War Medicine* that the fact that these survivals occurred when the necessary factors were accidentally contributed indicates the possibilities of increasing survivals and reducing injuries from automobile and airplane accidents by structural alterations in design that might be introduced. *War Medicine* is published by the American Medical Association in cooperation with the Division of Medical Sciences of the National Research Council.

"The human body," he concludes, "can tolerate and expend a force of two hundred times the force of gravity for brief intervals.

"It is reasonable to assume that structural provisions to reduce impact and distribute pressure can enhance survival and modify injury within wide limits in aircraft and automobile accidents."

Explaining the purpose of his paper, Mr. DeHaven says: "During the interval of velocity change in aircraft and automobile accidents many typical crash injuries are caused by structures and objects which can be altered in placement or design so as to modify the large number of severe and constantly recurring patterns of injury in these accidents. In order conscientiously to approach some of the engineering problems encountered in reduction of the potential injury hazards of windshield structures, seats, instrument panels, safety belts, etc., it was necessary to have some understanding of the limits of mechanical strength of the human body.

"The objective in studying the physiologic results of rapid deceleration in the following instances of extraordinary survival—after free fall and impact with relatively solid structures—was to establish a working knowledge of the force and tolerance limits of the body. On the basis of these data certain engineering improvements can be considered for aircraft and automotive design.

"Loss of pilots through injury due to the increased landing speeds of military planes has become more and more frequent; this loss and the ever present toll by accident in the automotive field are matters of grave national concern. Injuries in these fields are mechanical results stemming from localized pressures induced by force and applied to the body through the medium of structure. It is an axiom in the mechanical arts that modification of cause will change results, but the nature and the degree of structural alteration to modify injury to human beings effectively depend on the reactions of

the body to abrupt pressure and its distribution. The strength of human anatomic structure and its tolerance of pressure increase are centrally important elements in any proposed increase of safety factors through engineering effort.

"Obviously, if the body could tolerate pressure within only narrow limits, few improvements would be worth consideration, since the force and resulting pressure of a severe crash are at best formidable. Evidence, on the other hand, that the body can tolerate the force of an extreme crash—without injury—would indicate that (1) extreme force within limits can be harmless to the body; (2) structural environment is the dominant cause of injury; (3) mechanical structure, at present responsible for recurring injury, can be altered to eliminate or greatly modify many causes and results of mechanical injury, and (4) the greater the evidence of body tolerance of force and pressure, the wider the possibility for considering engineering improvements. . . ."

Mr. DeHaven points out that evidence of the extreme limits at which the body can tolerate force cannot be obtained in laboratory tests nor gained satisfactorily from most aircraft and automobile accidents. Estimation of the exact speed of a crash is difficult under most conditions, as is the determination of other essential factors.

"With the thought of overcoming many of these difficulties," Mr. DeHaven says, "and in order to observe physiologic reactions to force under more simple conditions, a study of cases of free fall was undertaken. In several of the cases outlined here speed of fall, striking position, deceleration and relation of resultant injuries to structure [object struck by the falling body] could be determined with great precision. . . ."

"The material is presented with the hope that additional instances of force survival may be closely observed and recorded in order to further an understanding of the strength of the body and the type of structure, position, etc., contributing to force survival.

"It is, of course, obvious that speed, or height of fall, is not in itself injurious. Also a moderate change of velocity, such as occurs after a ten story fall into a fire net or onto an awning need not result in injury, but a high rate of change of velocity, such as occurs after a ten story fall onto concrete, is another matter. Between these two extremes lies important evidence of physiologic force tolerance. . . ."

He explains that in using the expression "free fall" he means a fall free of any obstruction other than that encountered at its termination. He cites the following 7 cases in which the victim of the fall survived.

A woman aged 42, 5 feet 2 inches tall and weighing 125 pounds, jumped from a sixth floor and fell 55 feet onto fairly well packed earth in a garden plot, landing on the left side and back. The deceleration distance, i.e., the distance traveled by the body from the time its downward movement began to be reduced by contact with an object until it came to a complete halt, was about 4 inches as indicated by marks of the body in the earth. At the time the body struck the ground it was traveling at a velocity of 54 feet per second or 37 miles per hour. There was no evidence of material injuries or shock and no loss of consciousness. The superintendent of the building reached the victim immediately after she struck the ground. She raised herself on her left elbow and remarked: "Six stories and not hurt."

In case 2, a woman aged 27, 5 feet 3 inches tall and weighing 120 pounds jumped from a seventh floor window and fell 66 feet onto a wooden roof, landing head first with progressive contact of the shoulders and the back. This woman broke through a roof of $\frac{3}{4}$ inch pine boards which were supported on 6 by 2 inch beams 16 inches apart and landed lightly on the ceiling below.

Velocity at contact was 40 miles per hour. A hole approximately 16 by 16.5 inches was sheared in the roof by the force of the fall. Three of the 6 by 2 inch beams were broken. The only head injury was a lacerated scalp. There were abrasions over a portion of the spine and a fracture of one of the vertebrae. Commenting on this case, Mr. DeHaven says that "the fall was first known to have occurred when the woman appeared at an attic door and asked for assistance. She sat up in bed at the hospital later in the day. It is difficult to reconcile the structural damage to the beams with the absence of greater bodily injury in this case."

In the third case a woman aged 36, 5 feet 4 inches tall and weighing an estimated 115 pounds jumped from an eighth floor and fell 72 feet onto a fence, face downward. Velocity at contact was 44 miles per hour. There was no evidence of material injury. She landed "jack-knifed" over the fence, tumbled to the ground, got up and walked to a nearby clinic for first aid.

A rapid, uneventful recovery was made by another woman after she had jumped from a ninth floor, falling 74 feet onto an iron bar, metal screens, a skylight of wired glass and a metal lath ceiling. She landed face downward, prone. The velocity at contact was 45 miles per hour, at which speed she struck an iron bar with her chest, making a bend 13 inches deep in the bar. She had minor injuries to the head from the screen wires and fractures of the fourth, fifth and sixth rib on the right side.

A fractured rib on the right side and a fractured right wrist were all the injuries suffered by another woman who jumped from a tenth story window, falling 93 feet into a garden where the earth had been freshly turned. Velocity at contact was 50 miles per hour. She landed on her back. She was released from the hospital twelve days later.

A man, aged 43, fell 108 feet from a tenth story window and landed on the hood and fenders of an automobile, face downward. Velocity at contact was 52 miles per hour. He suffered a depressed frontal skull fracture but the immediate cause of this injury was not determined because he had bounced from the car to the pavement. He survived and is now in good health.

In case 7 a man jumped from the roof of a fourteen story building, falling 146 feet onto the top and rear of the deck of a coupe and landing partly on his back. Velocity at contact was 59 miles per hour. He fractured his left elbow, his left arm, his left shoulder blade, the seventh and eighth dorsal vertebra and his hip. He was conscious and there was evidence of some internal injury. There were no head or chest injuries. He returned to work two months later.

MEDICAL EPONYM

Murphy Maneuver

On December 18, 1902, Dr. John Benjamin Murphy (1857-1916) described the following diagnostic maneuver, to which his name is frequently given, before the New York Academy of Medicine. His paper appeared in *Medical News* (82:825-833, 1903), under the title, "The Diagnosis of Gall-Stones."

"... The most characteristic and constant sign of gall-bladder hypersensitiveness is the inability of the patient to take a full, deep inspiration, when the physician's fingers are hooked up deep beneath the right costal arch below the hepatic margin. The diaphragm forces the liver down until the sensitive gall-bladder reaches the examining fingers, when the inspiration suddenly ceases as though it had been shut off. I have never found this sign absent in a calculous or infectious case of gall-bladder, or duct disease."—R. W. B., in *New England Journal of Medicine*.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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KARL L. SCHAUPP, M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON.....Executive Secretary

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Plastic Surgery:

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Neuropsychiatry:

John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

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Erle Henriksen, Los Angeles.
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Pediatrics:

William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:

Alvin J. Cox, San Francisco.
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Radiology:

R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:

Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:

Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

OFFICIAL BUSINESS

Abstract of Minutes: California Medical Association Executive Committee*

Minutes of the One Hundred Seventy-Seventh Meeting of the Executive Committee of the California Medical Association, Held in San Francisco, Saturday, July 11, 1942

The meeting was held in Room 214 of the Sir Francis Drake Hotel, in San Francisco, on Saturday, July 11, 1942, at 12:30 noon, Chairman Henry S. Rogers, presiding.

(a) Minutes:

Minutes of the Organization Meeting of the Executive Committee, held at Del Monte, on Thursday, May 7, 1942, were approved.

(b) Discussion of Basic Science Initiative:

It was stated that the Basic Science Initiative would be Number Three (3) on the November ballot.

Discussion was had on who should sign the argument in favor of a Basic Science Initiative that would be sent by the State Authorities to voters prior to the November election. It was agreed that an invitation be extended to Doctors Ray Lyman Wilbur of Stanford University, President Tully Knowles of the College of the Pacific, and President Rufus von KleinSmid of the University of Southern California.

(c) Steering Committee:

After other discussion, it was agreed that a Steering Committee to supervise the campaign, consisting of Doctors John W. Cline of San Francisco, Frank R. Makinson of Oakland, and John W. Crossan of Los Angeles, be appointed.

(d) Report by Mr. Read:

Mr. Ben Read, of the California Public Health League, stated that a total of 230,179 valid signatures had been submitted to the Secretary of State.

It had been necessary, at considerable additional expense, to continue securing signatures after the minimum 212,000 had been secured.

(e) Financial Report by Mr. Hunton:

Mr. Hunton reported on the expenses incurred to date.

(f) Program for Publicity and Educational Campaign:

Discussion was had on publicity work, and certain activities approved.

(g) Adjournment.

HENRY S. ROGERS, *Chairman*,
GEORGE H. KRESS, *Secretary*.

The threads of all the Sciences are woven into the fabric of the clinic.

The three L's of longevity: Low weight, low pulse rate and low blood pressure.

Diagnosis by intuition is a rapid method of arriving at a wrong conclusion.—*J. C. da Costa*.

† For complete roster of officers, see advertising pages 2, 4, and 6.

* Full minutes of the Executive Committee meeting have been mailed to all councilors, and copies are also available for inspection in the central office of the Association.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Recent Visit of Colonel Sam F. Seeley to California (COPY)

CALIFORNIA MEDICAL ASSOCIATION
450 Sutter, San Francisco

July 29, 1942.

To the Members of the California Medical Association:
Dear Doctors:

California will be honored from August 3 to 10 by the appearance of Colonel Sam F. Seeley, Army Medical Corps, Executive Officer of Procurement and Assignment Service, at a limited number of meetings in our state.

Colonel Seeley will bring to us the latest information on Procurement and Assignment Service and will have the answers to any questions you may have on this service and on Army Medical Corps needs and requirements.

The following is the schedule of meetings which have been arranged for Colonel Seeley:

Monday, August 3, 1942, 8 p.m., Colonial Ball Room, Hotel St. Francis, San Francisco.

Tuesday, August 4, 1942, 8 p.m., Hotel Oakland, Oakland.

Wednesday, August 5, 1942, 8 p.m., Sacramento Senior High School Auditorium, 34th Street at Broadway, Sacramento.

Thursday, August 6, 1942, 8 p.m., Fresno Memorial Auditorium, Fresno.

Friday, August 7, 1942, 8 p.m., Los Angeles County Medical Association Auditorium, 1925 Wilshire Boulevard, Los Angeles.

Saturday, August 8, 1942, 7:30 p.m., Mercy Hospital, Nurses Auditorium, San Diego.

IF you are under 45 years of age—

IF you contemplate entering Army service—

IF you are available for a change of location—

IF you have any questions on the Army or on P. & A.—

The whole program of Procurement and Assignment Service will be covered, and questions asked from the floor will be answered. Your own immediate individual future and the whole future of medical practice is closely bound up in the program of Procurement and Assignment Service, and the success or failure of this program. The war effort of the medical profession is entirely channelled through Procurement and Assignment Service.

These meetings are for your benefit and you should let nothing prevent your attendance at one of them.

Fraternally yours,

WILLIAM R. MOLONY, SR.,
President.

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (FEderal 1953).

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

C.M.A. MEMBERS IN MILITARY SERVICE**

Marin County Medical Society

Members of the Marin County Medical Society on Active Duty with the Army and Navy.

(Report, as of July 15, 1942. Total Number, 11.)

Name	Rank (if known)	Service (if known)
Cannon, Frank.....		Navy
Cleave, David.....		Army
Conroy, B. J.....		Public Health Service
Goddard, A. B.....		Army
Goddard, W. P.....		Navy
Hammond, H.....		Army
Larson, Leonard.....		Army
Reynolds, W. J.....		Army
Schwarz, Al.....		Army
Stanley, L. L.....		Navy
Thusen, A.....		Navy

Medical Library Association War Service

Recent Activities of Library of Los Angeles County

Medical Association: Contacts with

California Army Camps

The National Medical Library Association, at the annual meeting held in New Orleans in May, 1942, took action on the Defense Proposition as follows:

"The Medical Libraries of the United States, through their organization in the Medical Library Association, are desirous of extending the use of their facilities and their trained personnel to the medical services of the armed forces of the United States. Our two hundred and fifty organized medical libraries located in all parts of the country are equipped to give library service to physicians now on duty in camps, hospitals and training stations."

1 1 1

The service will consist of the complete use of material within the library when it is possible for officers to go there. In addition a loan service will be instituted, of such material as the library is able to lend, package libraries of recent reprints, unbound periodicals, etc.

The country was divided into ten regional districts. A committee was named with a director for each district. Mrs. Mary E. Irish of the Los Angeles County Medical Association Library was named for the South Pacific States, California, with its great number of camps, etc., Nevada, and Utah. Miss Mary Louise Marshall, President of the Medical Library Association, will head the Committee, and Colonel Harold W. Jones, Librarian of the Army Medical Library, will act as advisor. All medical librarians in the district will act in coöperation with the director, and requests for material will be sent to the nearest library. An officer in the camp or a librarian will be responsible for the return of the material to insure against loss by removal of troops.

One of the greatest needs of this service, aside from the writing of papers, is the fact—as expressed by Dr. Kress in talking this over with him—that many doctors will be entirely out of touch with the advancement of medicine by being placed where there are no library facilities, and entirely at a loss when they are ready to take up their work when they return from service.

Military camps and hospitals that wish to establish medical libraries of their own may call on established medical libraries for duplicate material.

The library service is not only extended to doctors

** County Society Secretaries are requested to submit the lists for their respective counties.

whose homes are in the State, but to any physician who is located in camps included in the district. Doctors from California will receive the service from the libraries in the district nearest to which they are located.

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The exhibit of the Library of the Los Angeles County Medical Association at the annual meeting of the California Medical Association at Del Monte, May, 1942, presented a map of California showing the location of military camps in the State, and a statement of the service that the library will give to the doctors of California stationed in the camps.

Members of the Medical Corps of Army and Navy are cordially invited to feel free to avail themselves of the facilities of the Library of the Los Angeles County Medical Association (address: 634 South Westlake Ave., Los Angeles. Telephone, Fitzroy 7694. Librarian, Mrs. Mary E. Irish).

Procedure for Physicians Called by Local Draft Boards

A recent issue of the *War Bulletin* of the Ohio State Medical Association gave the following information. (Where indicated, California references have been inserted.)

What should a doctor do if he is placed in Class 1-A by his local draft board and told that he must enter the Army, even though the Procurement and Assignment Service may have advised the board that the physician is "essential" to the community?

First, it should be understood that *Selective Service is the final judge* and authority, having complete compulsory powers. *Procurement and Assignment is only "advisory,"* without compulsory powers and its advice need not be accepted by Selective Service, although in most instances Selective Service has been following the advice of Procurement and Assignment.

Second, when a physician is confronted with such an order from his local draft board, *he should immediately complete an application for a commission*, and ask for a final type physical examination for those applying for a commission. The Ninth Corps Area Surgeon's Office will accept his application and provide him with a physical examination. Or, the same service will be provided by either of the two Medical Officer Recruiting Boards, the addresses of which are given in the footnotes to the caption of this department of CALIFORNIA AND WESTERN MEDICINE. Information as to when the recruiting boards can be seen may be obtained from the California Procurement and Assignment Committees.*

Third, after such doctor has filed an application for a commission, he should get from the Corps Area Surgeon's Office or the Recruiting Board Officer, some statement to the effect that he has done so and he *should show this to this local draft board*.

Fourth, acting on the advice of State Selective Service Headquarters, *the local draft board is expected to grant such physician limited deferment until he receives his commission*. After receiving his commission, the physician, obviously, is no longer under the jurisdiction of Selective Service and he will enter the service as a commissioned medical officer. If, being declared available by his local Selective Service Board and the Procurement and Assignment Service, a physician declines to apply for a commission, or refuses to accept a commission when offered, he is subject to the control of the Selective Service Board and there is nothing the Procurement and Assignment Service can do about it.

State Civilian Defense Medical Officials Commissioned in U. S. Public Health Service

To facilitate the emergency medical and hospital program now being developed by the Medical Division of the Office of Civilian Defense and the U. S. Public Health Service, physicians who are State and deputy State chiefs of Emergency Medical Service in most of the coastal States have now been commissioned in the Public Health Service Reserve so that they may exercise both State and Federal responsibilities. . . .

These officers will have as their first duty the stimulation and guidance of local chiefs of Emergency Medical Service in the organization of local casualty receiving hospital and field casualty services. In addition to these functions, they will serve as responsible agents of the States and of the Medical Division of the Office of Civilian Defense and of the Public Health Service for the organization of emergency base hospital facilities and personnel.

In collaboration with State hospital officers, who are now being appointed in coastal States, the full-time Emergency Medical Service chief and deputy chiefs will plan the number, size, location, staff and equipment of Emergency Base Hospitals. Another duty of these officials will be to determine, in collaboration with the local military and the State evacuation authorities, the lines of evacuation and means of transport of civilian casualties and other hospitalized persons from local casualty receiving hospitals to Emergency Base Hospitals. In addition, these officers will review and certify bills to be submitted to the Public Health Service for payment for the hospital care of civilian casualties.

As of July 1, the following have been commissioned in the active reserve of the Public Health Service as State or deputy State chiefs of Emergency Medical Service to carry out this program:

For California: Dr. Charles F. Sebastian.

Proposed Salary Increase for Flight Surgeons

Additional Pay for Flight Surgeons.—Under existing law regular flying officers are entitled to extra compensation at the rate of 50 per cent of their regular pay. Flight surgeons, however, are restricted to payment at the rate of \$720 per annum as extra pay for flight. Under a provision contained in the Military Establishment appropriation bill for 1943, H.R. 7280, flight surgeons will be given the same extra pay as are regular flying officers, namely, extra compensation at the rate of 50 per cent of their regular pay. In recommending this change in the law, the House Committee on Appropriations, said: . . .

"Mr. Powers.—Colonel Moore, the chairman made a statement a few moments ago which impressed me very, very much, and I want to repeat it for the record at this point, quoting the chairman:

I might say that I am one of those who believe that you cannot buy patriotism, nor can we adequately pay for it. But we can help tremendously in these ways to promote the morale and make things somewhat more decent for those who must do the actual flying.

"From the information you have given us, that you have already lost five in action, that six are unreported, either dead or captured, and that you are evacuating, God knows how many critically wounded men by air, I think it might be well for all of us, when we mark up the bill, to give the subject of flight pay even more serious consideration that we have given it in the past. Your information has certainly been most interesting and most enlightening. Thank you." . . .

* For addresses, see footnote on previous page.

On Medical Needs of New York

The Public Relations Bureau of the Medical Society of the State of New York in a recent bulletin in its "Medical News" had the following to say concerning New York's need for physicians, as interpreted by the Medical Preparedness Committee of the State Medical Society:

Dr. L. H. Bauer, chairman of the Medical Preparedness Committee, stated that the number of physicians essential to any community depends to a certain extent on local conditions. No official national standard has ever been set up, and for this reason the New York State Medical Society has recommended to county societies a working basis for determining this factor.

"During the current emergency," said Dr. Bauer, "one general practitioner is essential for each 1500 population. This number will vary with the density of the population. In rural communities where there are long distances to be traveled the proportion will have to be one to less than 1500. In densely populated communities it might be extended to a little more than one in 1500. Besides these general practitioners there are certain specialists which will be required. The number and character of these specialists will depend on local conditions. For example, in an industrial community more surgeons will be required than in a strictly rural community. The number of specialists necessary for any given community will have to be determined in that community.

"In order to operate efficiently, hospitals must have minimum staffs. Also, certain physicians will be necessary for maintenance of the department of health, the medical examiner's office, and other public services.

"Certain physicians may hold key positions in civilian defense but so far as possible these should be drawn from the group not eligible for military service.

"As a general rule it is felt that no physician should be marked essential in the community who is 37 years of age or under. There will be occasional exceptions to this rule but they should be few. Physicians considered essential to the community should be from the group 45 years of age and over, and from the women physicians. In case the number in these groups is inadequate for the locality's need, temporary deferment should be asked from among the group between 37 and 45. This group should be re-assessed every six months. A number of the group 37 and under will be physically disqualified and will, therefore, be available to the community and thus release a certain number of the group between 37 and 45 for service. Hence the necessity of re-assessment of this group every six months.

"Hospitals should be asked for a list of those whom they consider essential but they should be advised of these basic recommendations and asked to keep their essential lists within these limits. Many hospitals can call on their consulting and retired staffs for service during the emergency, thereby releasing some of the attending staff. Certain hospital services can also be combined for the period of the war."

Chiropody Officers in the Army Medical Corps

Senate Bill 2597, introduced June 15, by Senator Hughes, of Delaware, for Senator Reynolds, of North Carolina, a bill to provide for the appointment of chiropody officers of the United States Army. Pending in the Senate Committee on Military Affairs.

Comment.—This bill provides that the Surgeon General of the Army shall appoint qualified officers in such numbers as will provide at least one chiropodist for each base hospital and training camp. Such officers will be commissioned as members of the Medical Corps of the United States Army in such grades as the Surgeon General deems advisable. A candidate must be a citizen of the United States, of good moral character, licensed to

practice chiropody in a State or in the District of Columbia, and must have been actively engaged in the practice of his profession for two years or more. The Secretary of War is directed to constitute examining and review boards, to pass on the qualifications of men eligible for such appointments. The bill also provides for the establishments "within the Medical Corps provision for chiropody (podiatry) Reserve Officers in accordance with the provisions of the National Defense Act and the amendments thereto."

• • •

Apropos of the above the following facts received from the British Board of Registration of Medical Auxiliaries may be of interest.

Two Hundred Chiropodists Are Corporals Looking After British Army's Feet

Britain is taking special care in this war of the feet on which her troops will join in the march to victory. Corns, bunions, ingrowing toe-nails and other foot troubles, already much less prevalent than in the last war owing to mechanized transport, are now to be altogether banished.

Already over 200 qualified chiropodists ranking as corporals have been appointed to military centers, and 40 women, with another 60 on the way, have been given similar appointments in the Auxiliary Territorial Service.

Special mobile units and chiropody traveling outfits are now in use to make sure that every man in the Army needing expert treatment gets it, however remote his station.

The second of the mobile units to go into service is an adapted 10 cwt. Ford van fitted with patient's chair, operating stool, trolley dressing table, electric nail drill and sterilizer and a cabinet of medicaments, instruments and so on.

The traveling outfits, twelve of which have already been made, are for the R.A.M.C. chiropodist corporal at military centers. Equipped with one of the cases, about the size of a portable gramophone, he can easily carry all his instruments, medicaments and towels.

California Procurement and Assignment Service: Recent Meetings

Col. Sam F. Seeley Explains Procurement Objectives

Recruiting of medical officers for the Army, Navy and Air Force was given added impetus early this month when Lt. Col. Sam F. Seeley, executive officer of Procurement and Assignment Service, made a ten-day tour of California. Colonel Seeley appeared as guest speaker at mass meetings in San Francisco, Oakland, Sacramento, Fresno, Los Angeles and San Diego, and in each city was greeted by a large attendance.

Stressing the need of the Army medical corps for a large number of officers, Colonel Seeley discussed at these meetings the development of Procurement and Assignment Service as a voluntary agency of the Government, concerned with the orderly recruitment of medical officers and the maintenance of adequate civilian and industrial medical resources. As to present Army needs, he showed that every able-bodied physician under 37 years of age was slated to be in Army uniform within the coming 12 months.

California has been slow in meeting its quota of Army medical officers, Colonel Seeley told his listeners, but now is coming up to par. His own prediction was that California would meet its quota on the basis of today's recruitment figures.

Accompanying Colonel Seeley on his tour of the state were Dr. Harold A. Fletcher, California chairman for physicians of Procurement and Assignment Service; Dr. Edward M. Pallette, California vice-chairman; Major F. Floyd South, Army recruiting board head in San Francisco; Lt. Cmdr. Leo L. Stanley, Navy recruiting head in San Francisco; Major C. A. Darnell, Army recruiting board head in Los Angeles, and Capt. J. B. Beare, Air Corps surgeon attached to the San Francisco Army recruiting board.

Military Clippings.—Some news items of a military nature from the daily press follow:

Service Need of Doctors Told

Enlistment Program to Be Outlined By Colonel

Forty-two thousand doctors, dentists and veterinaries must be serving with the armed forces by the end of this year, Col. Sam F. Seeley, executive officer of the Procurement and Assignment Service in Washington, D. C., declared here yesterday.

Colonel Seeley, who is in San Francisco for two days to outline and explain an enlistment program for California doctors, pointed out that at no time in history had there been such severe demands made upon the medical profession.

"Before the end of the war we expect every doctor under 45 years of age in the United States to be in a uniform," he said.

Not only must his office see to it that the armed services have enough doctors, but it must make sure of an even distribution of physicians throughout the country to meet the needs of the civilian and industrial populations, the Colonel noted.

"It will be wise for the doctors to enlist now," he declared, "since no civil practice can possibly prepare a doctor for the problems he will meet in active service. It takes experience to be a military doctor."

Colonel Seeley, guest of honor at the Bohemian Club yesterday noon, met with members of the Ninth Corps Procurement and Assignment Service at the Sir Francis Drake yesterday afternoon, to plan a five month enlistment program, and last night addressed a mass meeting of doctors and dentists at the St. Francis Hotel.

He will leave tonight after addressing East Bay doctors in Oakland for an eight day tour of the State. Accompanying him will be Dr. Harold A. Fletcher, State chairman for physicians of the Procurement and Assignment.—San Francisco *Examiner*, August 4.

* * *

Army Wants All Doctors Under 37

All physically fit physicians and surgeons in the United States under the age of 37 will be serving as officers with the armed services before the end of the war—and much sooner than that—if the hopes of the Procurement and Assignment Service are fulfilled.

This was the message brought to nearly 1000 Bay Area physicians, dentists and veterinarians last night by Colonel Sam F. Seeley, executive officer of the service, in a talk at the Hotel St. Francis.

California, which already has contributed some 1800 physicians to the armed forces, has a quota of 1786 more by the end of the year, Colonel Seeley declared.

The Colonel charged a lack of response to appeals for volunteers. Despite early indications that 50 per cent of 159,000 doctors would apply for commissions, only 43 commissions had been granted by January 1 and only 3600 by May 1.

There are 37,000 physicians under the age of 37—an adequate number to fill the probable needs of the Army and Navy, Colonel Seeley said.

Every effort is being made, however, to maintain an even balance of medical men to take care of civilian and industrial needs at home, he explained.

During peace time there was one physician on the average for every 775 persons, but the wartime percentage will be decreased to one in every 1500, Colonel Seeley said.—San Francisco *Chronicle*, August 4.

* * *

Recruiting of Doctors for Army Speeded Up

Washington, July 16.—(INS.)—In an effort to obtain 20,000 additional doctors for the nation's expanding army by the end of this year, the war department today increased the number of medical officer recruiting boards in five states.

Two additional boards each have been authorized in New York, Pennsylvania and California, and one each in Massachusetts, Ohio and Illinois. One board is functioning in each of the other states.

Officials said that commanders of the army corp areas affected will select personnel of the new boards and provide quarters.—Fresno *Bee*, July 16.

* * *

National Health

Army's Need for Doctors Causes Shortage at Home

New York, June 20. (Wide World.)—The Army is asking for three to nine times more doctors per thousand soldiers than America's civilian population has.

The rate is six-and-one-half physicians a thousand soldiers, compared with three for favored New York city and two-thirds of a doctor per thousand and in some rural areas.

The assurances face mothers, fathers and the public:

1.—The best medical care in history for our soldiers.

2.—Medical shortage at home which may be serious in places.

Our Army had about 1200 doctors before 1940, has about 15,000 today with 16,000 more entering service as rapidly as the careful induction systems can take them. The Navy accounts for an additional 10,000 physicians in service.

Civilian Problems

The estimates are from 58,000 to 60,000 doctors in military service in a couple of years. That is one-third of all the physicians in the Nation, including those retired or superannuated. More critical—at home but not for the soldiers—that number is three-fourths of all our doctors of 45 or under.

There is talk of reducing the Army rate to five and one-half doctors per thousand soldiers, without any drop at all in medical care, the saving all being made by dropping medical red tape. Under the military system, clerical and paper work has taken much of the doctor's time. That time is asserted to be equivalent to one doctor per thousand men. Medical corps clerks, who are not physicians, could be used.

The log jam for civilian medical care is immense. Leaders of the American Medical Association started more than two years ago preparing for possible war. They cleared the way for the Army and Navy. But, as in the case of the automobile and other great industries, the global war hit the medical profession with problems the likes of which never existed in the United States since pioneer days.

Typical logs in the jam are industrial defense areas. The Public Health Service is studying the needs of about 100 of these right now.

Samples include a community of 35,000 persons which was served by 28 physicians. That community is now 70,000 and the number of doctors is 15. The best are in service.

Crisis at Hand

The outlook is not black. But medically speaking a crisis is at hand. Flu, for example, is expected to return this year. The doctors are figuring how to beat this or other epidemics and the race is tight.

There are almost certainly doctors enough, even with one-third lost to military service. Sweden, for example, with a fine health record, has only one physician per thousand population. America's civilian population will have almost that many even with the maximum loss of physicians now envisioned.

The problems are how to spread the doctors, how to pay the bills. The solution may go far to fix in the post-war peace the rôle the Federal Government will take in medicine, in what is called State medicine.

The doctors themselves are showing the way to distribution of medical services. In replies to questionnaires which now have been answered by nearly all the 181,000 American physicians, thousands are volunteering to move into industrial areas or even into communities denuded by war requirements.

In the background are the refugee physicians. There are about 6000 of them in the United States, and of these probably no more than 1500 have been able to secure licenses. There is talk of Federal license permitting the others to do medical and health work on Government call.

The spirit among American physicians is:

"We shall do what the Government wants and like it."

—San Francisco *Chronicle*, June 21.

* * *

Army Doctors Taken Off Desk Duties

Washington, July 24.—(UP.)—Secretary of War Henry L. Stimson announced today that Army Medical Corps doctors now engaged in hospital administrative duties will be reassigned soon to purely professional work.

The doctors, Stimson said, will be replaced by members of the Medical Administrative Corps, trained especially to perform such duties. Personnel of the administrative corps is being drawn mainly from the enlisted ranks of the Medical Corps.—San Francisco *News*, July 24.

* * *

Blood Plasma Available

Pacific Coast to Get 7500 Units

San Francisco, July 3.—A supply of approximately 150,000 units of blood plasma will be available for treatment of civilian casualties throughout the nation in the

event of enemy action, the United States Office of Civilian Defense revealed today.

Dr. John B. Alsever, technical director of the blood plasma section of the O.C.D. Medical Division, now in San Francisco, said that the arrangements which had been completed between the O.C.D., the American Red Cross and the U. S. Army guaranteed the civilian population adequate protection in this medical necessity.

Some 30,000 units are now being distributed to hospitals in strategic areas throughout the country with 7500 units to be delivered to the Pacific Coast. Commercial laboratories engaged in preparing plasma for the armed services held an additional reserve of 30,000 units for civilian use, which would not be withdrawn unless actual need existed.

The Office of Civilian Defense has also contracted for the delivery beginning July 15 of 50,000 units of dried plasma from a Los Angeles laboratory and its medical division is supervising the preparation of an additional 40,000 to 50,000 units in private hospitals.

In the Ninth Region, Dr. Alsever added, the Red Cross bleeding centers at San Francisco and Los Angeles would, if necessary, devote all their facilities to collection of blood for civilian use. He stressed the need for blood donors for the Army and Navy and civilian defense and urged that civilians in all communities offer their blood to the Red Cross procurement centers or agencies operated by the Red Cross.—Los Angeles Examiner, July 4.

* * *

More Donations Asked Here for Blood Bank

The Surgeons General of the United States Army and Navy have requested that the American Red Cross furnish the armed forces as soon as possible, 2,800,000 units of blood plasma, during the next 12 months, it was announced here yesterday by Gurney E. Newlin, chairman of the Los Angeles Chapter, American Red Cross.

The blood plasma project was inaugurated in February, 1941 and has now developed into the largest controlled medical undertaking in United States history.

"Aside from being the largest controlled medical undertaking in our history, it is one of the most important at this time," Newlin pointed out, "to furnish this plasma to the medical corps of our Army and Navy.

"In this particular job the American Red Cross is the procurement agency. After the blood has been taken from individuals, it becomes the property of the Army and Navy and is turned over to the armed forces for distribution.

"The Red Cross has absolutely no control in distribution."

O.C.D. to Get Supply

"Through the Army and Navy arrangements have been made for the distribution of 150,000 units of blood plasma to the United States Office of Civilian Defense. This is to be used, according to agreement, in case of a major disaster and is available for treatment of civilian casualties.

"On the West Coast at the present time there are 7500 units available and a reserve of an additional 7500 units should the civilian population suffer from enemy bombing, any type of major disaster as a flood, tornado, earthquake, etc., or sabotage in our factories. This blood plasma can only be obtained through the chief of the Emergency Medical Services of the Office of Civilian Defense."

Newlin pointed out that because of the tremendous importance of securing blood plasma from volunteer donors that the Red Cross blood bank in Los Angeles has been asked to increase its weekly quota from 1885 units of plasma to 3000 units, which is necessary to meet the requirements of the armed forces and Office of Civilian Defense.

He stated that any limitation of this program might jeopardize the lives of our civilian population in times of an emergency and even cost the lives of a soldier, sailor or marine now serving with the armed forces.

Thanks Donors

Newlin expressed deep appreciation to the thousands of people who have donated their blood up to this time and particularly for those who have come back a second and third time to offer this life fluid for our boys or for their own loved ones in case of a disaster here at home.

He pointed out that virtually all hospitals in this area have blood plasma in stock for the ordinary every day emergencies that arise in a metropolitan city of this type.

This plasma or blood for transfusion purposes, is available under the same plan in civilian hospitals as it was before the war.

He made an urgent request that everyone physically fit give a pint of their blood to the American Red Cross blood bank by calling ROchester 0121 or calling personally at 925 South Western avenue.—Los Angeles Examiner, July 4.

Doctors, Nurses Aid Blood Plan

Doctors, nurses and technicians from various hospitals in Alameda County will volunteer their services to aid the Highland-Alameda County hospital operate the blood procurement program established to provide plasma for emergency civilian use, according to Dr. Benjamin W. Black, medical director of the hospital.

The program is expected to have its inauguration at the hospital this week, with 30 volunteer donors contributing a pint of blood each to swell the blood bank supply begun earlier at the hospital.

Beginning July 6, and continuing every Monday, Wednesday and Friday evenings from 7 to 9 o'clock, the supervisory committee expects to have the procedure in operation at increased capacity.

Dr. George F. Calvin, chairman of the committee, is in charge of the program, assisted by Dr. Gordon McLean and Dr. Gertrude Moore, members of the committee, and Dr. Glenn A. Pope, Highland hospital administrative assistant.

Through coöperation of the Oakland chapter of the American Red Cross, registration of volunteer blood donors is being taken daily at chapter headquarters, 108 Lake Street, by Red Cross Nurses' Aide personnel.—Oakland Post-Enquirer, June 29.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Institute on Wartime Industrial Health: Program Outline*

(San Francisco Meeting)

Sponsored Locally by San Francisco County Medical Society

Tuesday Afternoon and Evening—August 18, 1942
San Francisco—Hotel Clift

Chairman—Robert T. Legge, M.D., F.A.C.S.

Past President, Western Association of Industrial Physicians and Surgeons

- 2:00 p.m.—*Opening of the Institute*—John W. Cline, M.D., President, San Francisco County Medical Society, San Francisco.
- 2:10 p.m.—*Objectives of the Institute*—Robert T. Legge, M.D., Berkeley.
- 2:25 p.m.—*The Conservation of Industry's Manpower*—Carey P. McCord, M.D., Detroit, Michigan.
- 2:50 p.m.—*Industrial Hygiene in War Production*—J. J. Bloomfield, U. S. Public Health Service, Bethesda, Maryland.
- 3:10 p.m.—*Occupational Diseases and Their Control*—Harold T. Castberg, M.D., and Fred R. Ingram, M.S., State Department of Public Health, Berkeley.
- 3:55 p.m.—*The Physician's Legal Responsibilities*—C. H. Fry, Industrial Accident Commission, San Francisco.
- 4:15 p.m.—*The Surgical Management of Industrial Injuries*—Nelson J. Howard, M.D., San Francisco.
- 4:45 p.m.—*Discussion of papers.*
- 6:30 p.m.—*Informal Dinner.*
- 8:00 p.m.—*Management Looks At Industrial Health*—Frank P. Foissic, Waterfront Employers' Association, San Francisco.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

* For information concerning places and dates of meetings, see CALIFORNIA AND WESTERN MEDICINE, July, 1942, on pages 101-102.

- 8:20 p.m.—*Women At Work*—Carey P. McCord, M. D., Detroit, Michigan.
- 8:40 p.m.—*"Save a Day"*—U. S. Public Health Service motion picture.
- 9:00 p.m.—*Four Questions Answered*:
 Panel: Mr. Bloomfield Dr. Howard
 Dr. Castberg Mr. Ingram
 Mr. Foisie Dr. Legge
 Mr. Fry Dr. McCord

Speakers' Who's Who—Institutes on Wartime Industrial Health

- Bell, W. P., Crockett, California: personnel manager, California and Hawaiian Sugar Refining Corporation, Ltd.
- Bloomfield, J. J., Bethesda, Maryland: sanitary engineer; chief, States' Relations Section, Division of Industrial Hygiene, National Institute of Health, U. S. Public Health Service.
- Castberg, Harold T., M. D., Berkeley, California: passed assistant surgeon, U. S. Public Health Service; acting chief, Industrial Hygiene Service, California State Department of Public Health.
- Cherry, I. S., M. D., Huntington Park, California: president, Southeast Branch, Los Angeles County Medical Association.
- Cline, John W., M. D., San Francisco, California: president, San Francisco County Medical Society.
- Dart, E. E., M. D., Los Angeles, California: director, Division of Industrial Hygiene, Los Angeles County Health Department.
- Durkin, John J., M. D., Inglewood, California: president, Inglewood Branch, Los Angeles County Medical Association.
- Foisie, Frank P., San Francisco, California: president, Waterfront Employers' Association.
- Frees, Benjamin M., M. D., F.A.C.S., Los Angeles, California: chief surgeon, Armour & Company, Firestone Tire & Rubber Company; president, Western Association of Industrial Physicians and Surgeons.
- Fry, C. H., San Francisco, California: chief, Industrial Accident Prevention Bureau, California State Industrial Accident Commission.
- Howard, Nelson J., M. D., San Francisco, California: assistant clinical professor of surgery, Stanford University School of Medicine.
- Ingram, Fred R., M. S., Berkeley, California: supervising industrial hygiene engineer, Industrial Hygiene Service, California State Department of Public Health.
- Jelte, Safford A., M. D., Oakland, California: president, Alameda County Medical Association.
- Legge, Robert T., M. D., F.A.C.S., Berkeley, California: professor of hygiene (emeritus), University of California; past president, Western Association of Industrial Physicians and Surgeons.
- McCartney, O. D., M. D., Glendale, California: vice-president, Glendale Branch, Los Angeles County Medical Association.
- McCord, Carey P., M. D., Detroit, Michigan: medical advisor, Chrysler Corporation; medical director, Industrial Health Conservancy Laboratories; director, American Association of Industrial Physicians and Surgeons.
- Murray, A. R., Los Angeles, California: personnel manager, Owens-Illinois Pacific Coast Company.
- Perelle, C. W., San Diego, California: vice-president in charge of production, Consolidated Aircraft Corporation.

- Stead, Frank, Los Angeles, California: industrial hygiene engineer; chief, Division of Industrial Hygiene, Los Angeles County Health Department.
- Taylor, Walter L., M. D., Martinez, California: president, Contra Costa County Medical Society.
- Weiskotten, W. O., M. D., San Diego, California: president, San Diego County Medical Society.

COMMITTEE ON MEDICAL ECONOMICS

Rebates

Reference to the rebate evil is made in the minutes of the House of Delegates of the California Medical Association (see July issue of CALIFORNIA AND WESTERN MEDICINE, on page 67 for resolution introduced by Doctor Wilbur Bailey; and page 87, for report thereon by Reference Committee No. 3).

In accordance with the instructions given, C.M.A. Delegate Dwight L. Wilbur presented to the House of Delegates of the American Medical Association (see J.A.M.A., June 27, 1942, on page 724), the resolution which follows:

Resolutions on Rebates

Dr. Dwight L. Wilbur, California, submitted the following resolutions, which were referred to the Reference Committee on Amendments to the Constitution and By-laws, with which the Judicial Council will sit:

WHEREAS, The Principles of Medical Ethics of the American Medical Association in chapter III, article I, section I, states that "The obligation assumed on entering the profession demands that he use every honorable means to uphold the dignity and honor of his vocation, to exalt its standards . . ."; and

WHEREAS, Section 5 of the same chapter and article states that "It is unprofessional to receive remuneration from patents or copyrights on surgical instruments, appliances, medicines, foods, methods or procedures. It is equally unprofessional by ownership or control of patents or copyrights either to retard or to inhibit research or to restrict the benefit to patients or to the public to be derived therefrom. It is unprofessional to accept rebates on prescriptions or appliances, or perquisites from attendants who aid in the care of patients"; and

WHEREAS, Article VI, section 4, of this chapter states that "When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or receive a commission by whatever term it may be called or by any guise or pretext whatsoever"; and

WHEREAS, Section 5 of this same article and chapter states that "It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and to the welfare of the people, and is against sound public policy"; and

WHEREAS, Recent articles in magazines of wide national circulation have called attention to shady practices of secret rebates to physicians; and

WHEREAS, Commercial concerns and laboratories, by the employment of cappers and steerers, and by secret rebating are largely responsible for these criticisms; and

WHEREAS, The Better Business Bureau has complained of practices in which secret rebates were offered or accepted by physicians; and

WHEREAS, The dishonest acts of a few may be reflected to the discredit of the many; now, therefore be it

Resolved, That it be declared unethical for the members of the American Medical Association or its component branches to refer patients to commercial organizations, laboratories or other physicians who advertise to the public and others than the medical profession, who employ steerers or cappers or who offer to pay rebates or com-

missions or in any other manner violate the Principles of Medical Ethics of the American Medical Association or its component branches; and be it further

Resolved, That any physician violating these resolutions be subject to whatever disciplinary action is deemed advisable by the county society of which he is a member.

* * *

The action taken by the special committee of the A.M.A. House of Delegates, after conference with C.M.A. delegates and others, follows:

Report of Reference Committee on Amendments to the Constitution and By-laws

Dr. Walter E. Vest, Chairman, presented the following report, which was adopted section by section and as a whole on motions of Dr. Vest, duly seconded and carried: . . .

2. Resolutions on Rebates

Your reference committee has given very serious consideration to these resolutions. It is the opinion of your reference committee that the practices referred to in the resolutions are beneath the dignity of a learned profession, are basically dishonest and are a violation of the Principles of Medical Ethics. Your reference committee therefore recommends that the following substitute resolutions be adopted.

WHEREAS, It has been brought to the attention of the House of Delegates that the unscrupulous practice of rebates to physicians is being engaged in by various commercial organizations, laboratories, supply houses and in some professional relationships between certain physicians; and

WHEREAS, All such practices are clearly in violation of the Principles of Medical Ethics; therefore be it

Resolved, That the House of Delegates of the American Medical Association express stern disapproval of the practice by any of the members of its component societies of referring patients to commercial organizations, laboratories or other physicians who advertise to the public and others than the medical profession, who employ so-called steerers or cappers or who pay, or offer to pay, rebates or commissions in any guise whatsoever, or who in any other manner violate the Principles of Medical Ethics of the American Medical Association; and be it further

Resolved, That any member violating these resolutions be subject to such disciplinary action as is deemed advisable by the county society in which such physician holds membership; and be it further

Resolved, That the Secretary of the American Medical Association be instructed to send a copy of these resolutions to each state and county society, accompanied by a letter to the secretary of each setting forth that all such unethical practices are disreputable and unscrupulous and, if not controlled, may soon besmirch the reputation of the entire medical profession.

Respectfully submitted,

WALTER E. VEST, *Chairman*,
WALTER F. DONALDSON,
KARL S. J. HOHLEN,
EDWARD M. PALLETTE, SR.,
WILLIAM WESTON.

* * *

Resolutions on Improvement of Relations Between Physicians and Insurance Companies

For reference to actions by C.M.A. House of Delegates, regarding "Improvement of Relations between Physicians and Insurance Companies," see CALIFORNIA AND WESTERN MEDICINE, July, 1942, on page 67.

The resolution adopted at Del Monte was presented to the A.M.A. House of Delegates in Atlantic City by C.M.A. Delegate Lyell C. Kinney (see J.A.M.A., July, 1942, on page 728 and 729).

Dr. Lyell C. Kinney, California, presented the following resolutions, which were referred to the Reference Committee on Legislation and Public Relations meeting jointly with the Reference Committee on Miscellaneous Business:

WHEREAS, It is desirable that physicians and insurance companies coöperate to the fullest extent, especially in the interest of persons covered by health and accident insurance; and

WHEREAS, A serious situation has arisen in the administration of certain health and hospitalization schemes whereby medical services are being billed under the term "hospital services" and are being paid for by insurance companies as they are labeled hospital services; and

WHEREAS, The continuation or extension of such practices will inevitably lead to the inclusion of any type of medical service under the label "hospital service," at the convenience of the corporations involved and to the detriment of medical care; now therefore be it

Resolved, That the House of Delegates of the American Medical Association hereby requests insurance companies to coöperate with the organized medical profession to the end that hospitalization policies shall include only hospital benefits. If the inclusion of indemnification for medical services, such as surgery or radiology, is desired, then payment of such shall be made only on receipt of certified statement from a physician that he has rendered such. Fees for medical services should be paid to physicians via indemnity to the assured, or by check payable jointly to assured and physician. This practice should be maintained irrespective of whether a hospital chooses to bill for medical services as a part of its hospital bill; and be it further

Resolved, That the House of Delegates of the American Medical Association requests hospitals and physicians to coöperate with it in this important step, by seeing that bills for hospital and medical services are clearly distinguished; the latter should bear the name of the physician rendering the service to indicate clearly that the charge is for medical service.

* * *

Report of Reference Committee on Reports of Board of Trustees and Secretary

Action of House of Delegates of American Medical Association, re: (a) Medical Service Plans, and (b) Program for Farm Security Administration

Dr. Louis H. Bauer, Committee Chairman, presented the following report, which was adopted section by section and as a whole on motions of Dr. Bauer, duly seconded and carried after discussion:

1. Report of Bureau of Medical Economics in Report of Board of Trustees

Two activities of the Bureau of Medical Economics in which no comment was made in the general report of your reference committee have been held over for further discussion, and the report follows. These activities are those listed as Medical Service Plans and the program of the Farm Security Administration.

(a) Medical Service Plans

A recommendation was made a year ago that the Bureau establish some method of coördination and interchange of material pertinent to the administration of prepayment plans for medical care sponsored by medical societies. The Bureau began a study of such plans, and data are coming in. It is contemplated that the Bureau will become a clearing house for factual data pertaining to the whole subject which will be available to all state and county medical societies.

It might be well at this point to review briefly the principles already adopted by the House of Delegates in 1938: 1. Hospital service insurance was approved in principle. It was felt that these plans should confine themselves to provision of hospital facilities and should not include any type of medical care. 2. It was recognized that health needs are not identical in different localities but depend on local conditions and, therefore, are local problems. 3. Cash indemnity insurance plans were considered practicable of development in order to cover in whole or in part the costs of emergency or prolonged illness. Such plans were also to have approval of the county and state medical societies of their respec-

tive areas. 4. A stand was reiterated against any system of compulsory health insurance. 5. A conviction was expressed that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. It was further stated that development of group hospitalization and establishment of insurance plans on the indemnity principle to cover the cost of illness would assist in the solution of these problems.

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As a result of the adoption of these principles, various organizations came into being. Not only is the cash indemnity principle being used, but medical service plans, some on the so-called unit plan, have also developed. Taken as a whole, progress has been slow and disappointing. It seems to your reference committee that there are two outstanding reasons for this. First, the public has not shown any great desire for such plans. Its attitude is often that it has always obtained medical care when and where it wanted it, and paid for it when and if it pleased—so why budget ahead for something it believes it can get anyway? The other reason is partly tied up with the first. The original idea of all such plans was to find some means of delivering good medical care to those in the economic group above indigence and below complete self sufficiency. This aim has to a large extent been lost sight of, and there has been a tendency to make the fee factor more important than the delivering of good medical care. One thing is certain, and that is that the development of sound, workable, voluntary plans will do more than anything else to avert the introduction of some compulsory plan.

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The Bureau of Medical Economics feels that the principles already adopted by the House are sound and should be adhered to and that there is nothing to indicate that medical service organizations and group hospitalization cannot function separately as parallel services in communities that are sufficiently interested to support them. Your reference committee agrees in general but feels that certain modifications are advisable:

1. Reiteration should be given to the fact that the aim of all plans should be to facilitate delivery of the best medical service to those who are in the economic group below self sufficiency.

2. To help carry this out, approval should be given to the principle of medical service for the low income groups, provided the local situation warrants and the local county and state medical societies approve.

3. The part to be played by the American Medical Association should be restricted to the adoption of broad general principles and to acting as a clearing house, as already planned by the Bureau of Medical Economics.

~ ~ ~

The idea that the American Medical Association can and should develop a plan on a countrywide basis is contrary to sound common sense. One of the claims we have always made in opposing state medicine is that medical control cannot be centralized. Conditions vary in different states and even in different counties in the same state. What will work in one locality is impracticable in another. Plans, therefore, should be largely local in character so far as details are concerned, and national only so far as broad general principles are concerned.

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The matter of the cash allowance of \$3 a day for hospitalization for those employed under the Social Security Act is not yet sufficiently definite for the House to take action on it. The matter should be referred to the Board of Trustees for appropriate action, if and when the matter becomes more definite.

(b) Program for Farm Security Administration

Medical care plans sponsored by the Farm Security

Administration are operating in more than nine hundred counties of thirty-seven states and involve more than one hundred thousand families and more than five hundred thousand persons. The Farm Security Administration now proposes what amounts to a voluntary health insurance plan for all farm families in an average county in one or more areas and would give more complete medical care than the present Farm Security plan does, all to be worked out between the county agricultural planning committee and the county medical society. Because financial conditions have changed for the better in farm communities since the original proposition was made, it is probably less urgent now. Furthermore, it requires more study than can be given it during this meeting. Therefore your reference committee recommends that the matter be referred back to the Board of Trustees for study and such action as it deems fit.

Respectfully submitted,

LOUIS H. BAUER, *Chairman*,
J. F. HASSIG,
A. R. McCOMAS,
WILLIAM R. MOLONY, SR.,
PARKE G. SMITH.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Basic Science Initiative (No. 3 on November Ballot)**

During the present lull in the primary election campaigns, before the candidates warm up to hot discussion of issues which will be settled at the polls on August 25, it might be well for voters to give some thought to the 18 propositions which will face them for decision in November.

Three of these ballot propositions are initiatives submitted to the people by petition, and one has been the subject of great controversy. It proposes a reorganization of the State's building and loan association laws to give better protection to certificate holders. The other two are for repeal of the State income tax and creation of a new State board of basic sciences which would govern the issuance of certificates attesting to a knowledge of the fundamental principles of the healing-arts.

In addition, there is one highly controversial proposal which will undoubtedly become an issue in the primary election campaign before the August election, although the people will not decide it until November. That is the hot cargo bill which was passed by the Legislature over the Governor's veto and was placed on the ballot for referendum. . . . —Oakland Tribune, July 5.

* * *

State Initiative Qualifies

Sacramento, June 26.—(INS.)—Submission of petitions bearing 165,376 signatures from Los Angeles County qualified a basic science initiative for the November general election ballot.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

** In this issue, for other comment, see editorial department, on page 115.

Sponsored by both the California Medical and Dental Associations, the proposed act would establish a new five man board to conduct examinations in basic sciences for license applicants. Candidates passing board examinations would then apply to the board of medical examiners or other licensing agencies for permits. The board would be appointed by the governor. . . .—*Fresno Bee*, June 26.

* * *

"Medical Academies" for the Nine Army Corps Areas

H.R. 7231 was introduced June 16 by Representative Dickstein, of New York, (a bill for the creation of medical academies). This measure proposes that there will be established in each corps area of the United States, as now constituted, a medical training school for the instruction of physicians for the armed forces and the United States Public Health Service. Each such school, it is proposed, will enroll a minimum of 295 students. Each Representative and Senator from the area comprising the corps will designate five principals and ten alternates and any vacancies will be filled by the commanding general of the army corps. Candidates for admission must be at least twenty years of age and not over twenty-five, must be graduates of a college or university or possess the qualifications for entrance into a medical school in the State of which they are residents. must be citizens of the United States and of good moral character.

No action has been taken on the bill. It is pending in the House Committee on Military Affairs. Representative Dickstein explained the purpose of his bill on the floor of the House June 16. After having expressed himself in opposition to the proposal submitted by the President for making loans to students pursuing accelerated courses, Representative Dickstein said in part:

"In view of this war, in view of what we expect to happen—and I hope it does not happen—we will need every man who is capable of taking care of and giving attention to our wounded veterans, and this will result in a better understanding amongst the American people. I am going to ask the Committee on Military Affairs for an early hearing. I propose to submit proof and evidence of what I have charged here today, and I defy any school, big or small, to deny these charges that very few can enter the schools because of the conditions that I have outlined this afternoon. I am not attacking the medical profession. I am attacking the undemocratic practice of discrimination which prevails in many medical schools. . . ."—*Legislative Bulletin*, No. 17.

* * *

Financial Aid to Medical Students

Financial Aid to Medical Students; Federal Medical Academies.—On May 28, the President transmitted to Congress a supplemental estimate of appropriations, in the amount of \$10,000,000, to assist students, in such numbers as the Chairman of the War Manpower Commission shall determine, participating in accelerated programs in degree-granting colleges and universities in engineering, physics, chemistry, medicine (including veterinary), dentistry, and pharmacy and such other technical and professional fields as are determined to be necessary in connection with the national war effort (House Document No. 744, 77th Congress).

Loans would be made, according to the proposal, to students, to enable them to pursue courses beyond the second collegiate year, who have attained and continue to maintain satisfactory standards of scholarship, who are in need of assistance, and who will agree in writing to participate, until otherwise directed by the Chairman of the War Manpower Commission, in accelerated programs of study in any of the fields named and who will

agree in writing to engage, for the duration of the wars in which the United States is now engaged, in such employment or service as may be assigned by officers or agencies designated by the Chairman, such loans to be made by the colleges and universities or public or college-connected agencies.—*Legislative Bulletin* No. 17, July 1, 1942.

* * *

Chiropractors and the United States Employees' Compensation Act.—The House Committee on the Judiciary has ordered the Tolan bill, H.R. 1052, favorably reported to the House, proposing to accord to chiropractors the right to treat beneficiaries of the United States Employees' Compensation Act. The bill has not as yet been actually reported but available information indicates that the Committee will complete action on the bill within the near future.—*Legislative Bulletin* No. 17.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Greatest War Health Problem: Syphilis

The greatest health problem facing the United States in World War II is syphilis, according to Captain C. S. Stephenson, head of the division of preventive medicine of the Navy's Bureau of Medicine and Surgery.

Control of the disease is of equal importance to the military and the industrial effort, in Captain Stephenson's judgment, and victory in this regard will not only hasten victory in the war but lead to lasting benefits for the entire population in postwar days.

Selective Service officials found 63,000 cases of syphilis in the first 1,000,000 men examined for the Army. This led the Public Health Service to increase its estimate of the extent of syphilis in the nation from 1 per cent of the population to 2 per cent.

The Navy, Captain Stephenson made clear, is interested in the problem from three approaches. First, it is interested in protecting the health of its own personnel. Second, it is interested in having a reservoir of healthy citizens from which to draw future personnel. Third, it is interested in seeing that disease does not reduce the industrial production without which the fighting forces are powerless.

"The fact must be faced that our nation must bring about in the shortest practicable time a great increase in the armed forces," Captain Stephenson said at the Atlantic City meeting of the American Medical Association.

At the same time, he believes that the nation must be prepared to deal with the health problems which will arise from the shift in populations which is resulting from expansion of old industries, the creation of new industries, and the general shift from a peacetime to a wartime production schedule.

"This rearrangement of population will create many health and social problems," he continued. "The great-

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Dwight H. Murray, Napa; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M.D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

est of these is syphilis, the control of which will greatly assist the military surgeon to conserve manpower and to increase the effectiveness of the armed forces."

The problem of syphilis, Captain Stephenson emphasized, is not primarily a problem of the treatment of the disease but one of prevention; of protecting the well from the diseased. In other words it is a problem of public health.

In this connection he pointed out that 64 years ago, Dr. J. J. Marion Sims, then president of the American Medical Association, stressed the necessity of a public-health approach to syphilis, urging that existing boards of health be given the same power over syphilis which they then possessed over cholera, smallpox and yellow fever.

"They now have the power of ferreting out these diseases and they should have the same power of searching out the abode of syphilis and of sending its victims to hospitals for treatment," Dr. Sims said in 1876.

But though Dr. Sims preached the right doctrine in 1876, Captain Stephenson says that no one tried to apply it until 1917 when Newton D. Baker, then secretary of war, took action.

Mr. Baker, he related, wrote to the governors of the states and the chairmen of the state councils of national defense: "I am determined that our new training camps as well as the surrounding zones within an effective radius shall not be places of temptation and peril."

Similar action was taken before our entrance into World War II, he added, by joint agreement of the War and Navy Departments, the Federal Security Agency, and state health departments.

This agreement, for the "control of the venereal diseases in areas where armed forces or national defense employes are concentrated," was implemented by Congress with the passage of the May Act. This act prohibits prostitution within areas designated by the Army and Navy.

* * *

How Healthy Are You?

A periodic health examination may add years to your life. Through the recognition of physical changes at the earliest possible moment the progress of menacing degeneration and infection may be stopped, and a suitable plan of living devised to maintain continuous health.

Too many of us never go near the doctor unless we suffer definite illness. We'll go on feeling "poorly" for weeks and months and even years. During those weeks and months and years disease may progress to the point where even modern science can't check it.

Medical authorities recommend that complete physical examinations be taken every year, and twice each year after we pass middle age. Those examinations should cover the entire physical system—lungs, heart, blood, the intestinal tract, teeth, feet, etc. In addition to the physical tests, the doctor will inquire into habits of sleep, rest, outdoor exercise, diet, and so forth. When that is done, the doctor will be able to write a health prescription. That prescription may not involve the taking of medicines. It may, instead, deal exclusively with such matters as rest, work, social adjustments and recreation. In any event, it will probably lengthen life—and make it healthier, happier, fuller.—*Tulare Times*, July 6.

* * *

Keep Healthy, Help Win the War!

Mindful of the soundness of the adage that "an ounce of prevention is worth a pound of cure," the Institute of Life Insurance has started a campaign to tell Americans how to avoid preventable illness. This war within a war, this battle against preventable disease has as its aim the maintenance of top-notch health and energy on the Amer-

ican home front at a time when every production hour counts, when every hour lost through illness that would have been prevented presents a situation that can impede the conduct of the war.

The situation's real seriousness perhaps can be better realized if it is known that by the end of this year 40,000 physicians and dentists and 35,000 nurses will be serving with the armed forces. This is nearly one-third of America's total medical force. Those who are left to take care of the civilian population will have their hands full and could easily be swamped with the work that one serious epidemic might cause.

Surgeon General Thomas Parran, Dr. Morris Fishbein, of the American Medical Association; Paul V. McNutt, federal security administrator, and others have been concerned with the potentialities of the problem unless the American people are sufficiently aroused to participate in a nation-wide health crusade.

The crusade consists of nothing more than following five simple health rules: Eat right—three meals a day of milk, butter, eggs, fish, meat, cheese and other key foods.

Get your rest—remember you cannot catch up on lost sleep.

See your doctor once a year—give him a chance before you get sick.

Keep clean—plenty of baths, fresh air and sunshine.

Play some each day—your mind and body need a change from the daily grind on the job.

These few rules make it easy to keep well. "Just by keeping well you can help win this war," is good advice.—*Napa Register*, July 13.

COMMITTEE ON PUBLICATIONS

Medical Writing—Re: An Article by Dr. Morris Fishbein

In a recent issue, the *Virginia Medical Monthly* printed a "guest editorial," the author of which was Morris Fishbein, M.D., editor of the *Journal of the American Medical Association*. The C.M.A. Council years ago approved the publication of a brochure, "Suggestions to Authors," copies of the same being available on application to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter, San Francisco. Doctor Fishbein's article, on Medical Writing, follows:

Increasing organization in the field of medicine, as in every other field of human endeavor, has introduced advancement in the production of contributions to medical literature. Far too often, however, there are still physicians who prepare their contributions with a striving and agony and delay quite comparable to the delivery of the human progeny by some one quite untutored in the possible refinements associated with that performance. Many a time the physician who has been asked to prepare a simple statement, constituting a review of available knowledge, for a local medical society, fails to inform himself concerning the innumerable agencies prepared to assist him in that simple task. He is likely to seat himself in his office or in his den at home, to surround himself with a liberal quantity of textbooks of more or less recent vintage and with periodicals selected at random, and then endeavor to collate this material in a single evening so that it may ultimately resemble something of usefulness to the physicians on whom it will be inflicted. The first information that this physician should possess is the importance of the preparation of a systematic, orderly scientific outline as the first step in

the preparation of a manuscript on any subject. Even the elementary courses in English composition now teach the significance of having an introduction, a body, summary and conclusion to any type of scientific essay.

Fundamental in the preparation of the manuscript on any scientific subject is a knowledge of the contributions already made to that subject by previous contributors. Now available to the physician is the best series of bibliographic references available in any field of human endeavor. The Index Catalogue of the Surgeon-General's Library, the Index Medicus, and the Quarterly Cumulative Index Medicus and, indeed, even the semi-annual indexes in *The Journal of the American Medical Association*, offer for every physician easily available guides to the most recent contributions on any medical subject. The simplest process is to place each bibliographic reference on a card or a sheet of paper, following the form prescribed for bibliographic references by leading medical publications; under this bibliographic reference should be placed a brief abstract or summary of the article concerned. The physician may then systematize the presentation of this material by classifying his cards under the classical headings developed by Sir William Osler in his textbook on "The Principles and Practice of Medicine," such as *history, etiology, diagnosis, symptoms, prophylaxis, prognosis, and treatment*, or he may choose to assemble his references in chronologic order. Thus, obviously, it merely becomes necessary to insert this material in the proper place in the outline of the presentation that he will make.

Professional writers in every field of literature have come to realize the importance of preparation of a manuscript for the publication to which it is meant to be sent. Some periodicals limit themselves to articles of 1,500 words; some periodicals are capable of handling large monographic presentations. *The Journal of the American Medical Association*, for instance, endeavors to limit practically all scientific contributions to six pages or not more than 6,000 words (preferably articles are much shorter). In the instance of special articles prepared for a specific purpose much greater latitude prevails. Obviously the physician who is preparing an article for a state medical journal, for one of the periodicals devoted to a medical specialty, or for any other medical periodical should be familiar with the nature of the publication and should plan his article according to the usual plan followed by the editor of that publication.

Many a medical writer has expressed the view that such limitations as are here mentioned interfere seriously with proper display of the individuality of the literary contributor. Actually one may utilize his literary accomplishments and style to far better advantage under some such orderly plan than when the writer gives free rein to his imagination and writes as the spirit moves him. One of my most respected teachers once said that the outward appearance of a manuscript, the character of its arrangement, the quality of its spelling and punctuation and choice of diction were excellent indications of the personal characteristics and scientific qualifications of the writer. The clinician or the research worker in the laboratory betrays in his literary contributions the possession or lack of ownership of a scientific mind.

Competition in the field of medical writing is certainly as great as that in the field of medical practice. The leading medical publications are constantly overwhelmed with offers of material. Many of the periodicals devoted to medical specialties find it necessary to hold manuscripts from six months to a year or more before space can be found for their publication. *The Journal of the American Medical Association* receives five times as many manuscripts as can be given room in its pages. Therefore, the physician who launches into the arena a literary venture poorly clad, unsound in its constitution, limping

in some of its sections, bruised by bad grammar, inadequately camouflaged in its obvious deficiencies, may expect to have his progeny returned with the simple but trite statement, "The editor regrets . . ."

C.M.A. CANCER COMMISSION†

(COPY OF MID-YEAR STATE REPORT)

FIELD ARMY

of

THE AMERICAN SOCIETY FOR THE CONTROL OF
CANCER, INC.

California State Division

State Commander, Mrs. Henry Ullmann

3 West Carrillo Street

Santa Barbara, California

MID-YEAR STATE REPORT

July, 1942

This is the first state report since the death of Dr. Charles A. Dukes, March 13, 1942. As chairman of the State Executive Committee, his broad vision and timely judgment was invaluable to us.

At the annual meeting of the California Medical Association, Dr. Harold Brunn, of San Francisco, was appointed chairman of the State Executive Committee.

Organization

The 1942 campaign report reveals marked progress within our state.

Counties actively organized, 31.

Executive Committee members, 250.

Advisory Board members, 376.

Commanders, officers and workers, 603.

Number of meetings held, 376.

State organizations coöperating, 47.

Educational Campaign

Literature has been distributed in every county within the state.

Total pieces of literature distributed, 170,000.

Number of display posters and counter cards, 766.

Educational meetings (lectures and showings of films), 569.

Specific educational work in colleges and schools:

a—Writing of essays.

b—Writing and producing radio skits.

c—Showing of films.

d—Work in Science classes.

e—Lectures.

f—Distribution of literature.

Publicity

The state publicity has reached out into new territories with articles, also reprints from the metropolitan papers have appeared in the smaller communities. The larger communities, in particular, report success with radio "spot" announcements and newspaper headlines.

Total items of publicity material released, 705.

Total number of newspaper inches rated, 2,006.

Total number of radio programs arranged, 18.

The Publicity Scrap Book has been compiled and sent to New York.

Enlistment Campaign

The State has failed to raise its quota which is 1 per

† For roster of members of the Cancer Commission of the California Medical Association, see page 2 in the front advertising section (bottom of the second column).

cent of the population. The official financial report is not complete, due to delay in returns from a few counties. This report will be issued at a later date.

General Items of Special Interest

Mrs. Emily G. Bogert, of Denver, Western Regional Deputy Commander, made an official visit in January, speaking in San Francisco, Fresno, San Diego, Los Angeles and Santa Barbara.

Can containers were designed and donated by the San Quentin Hospital.

Affiliation with the General Federation of Women's Clubs.

Reference books were placed in schools and public libraries.

Exhibit booth at state meeting of the California Medical Association.

Acknowledgment

The State Committee expresses its appreciation to the many who have contributed time, services and funds to make possible this educational program in California.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM...Asst. Chairman on Publicity

President Lindemulder's Report on the Twentieth Annual Convention of the Woman's Auxiliary to the American Medical Association

Atlantic City, New Jersey, June 8-12, 1942

Dear Auxiliary Members:

The Twentieth Annual Convention of the Woman's Auxiliary to the American Medical Association was held in Atlantic City, from June 8 to 12, 1942. The official headquarters were at the Hotel Haddon Hall, located on the famous Board Walk, in the heart of the city. The registration desk, meeting rooms, and exhibits were all on the lounge floor, which meant that the women were undisturbed during the entire convention.

Because so many previous medical conventions have been held in this beautiful Convention City, the Woman's Auxiliary to the New Jersey Medical Association had everything well in hand, and things ran very smoothly. Very little attempt was made to entertain the women other than with luncheons and a tea, for the shops and auctions located on the Board Walk, as well as a very inviting ocean, took up all the spare time between business sessions. Atlantic City is just fifteen miles from the sea lanes where there has been so much submarine activity, and there was a very efficient Dim-Out every evening. No cars were allowed to drive with any but dim lights, and all the shop windows were covered with a blue celluloid material, which cast an eerie glow over the promenaders, who, however, still promenaded as they did before this awful war.

When the members and guests registered, each one was handed an envelope filled with samples and recipe books which had been donated by the various exhibitors at the American Medical Association headquarters. It took the New Jersey women quite a bit of time to contact all these companies and obtain these for us.

† Reports of county chairmen on publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

On Monday, June 8th, at nine o'clock in the morning, Mrs. Mosiman, the National President, opened the meeting of the Board of Directors. At that time, I was able to meet and know who the various national officers were. It was explained to us that, now we have a National Executive Secretary, the entire setup of the organization will be different, for she would do much of the routine work that formerly had been done by the officers.

That afternoon, a delightful tea was given in the Garden Room, which overlooks the ocean, honoring Mrs. Mosiman and Mrs. Haggard, the incoming president. A string quartette entertained us with music during the tea. At this time it was possible to converse with the presidents of other State Auxiliaries and find out how they functioned.

Tuesday, June 9th, at ten o'clock in the morning, the formal opening of the Twentieth Convention took place in the Vernon Room, with Mrs. Mosiman presiding. The Address of Greeting was given by Mrs. J. H. Hornberger, who graciously welcomed us to their lovely city. Mrs. William Butler of Michigan, made the Response. Next Mrs. J. E. Weir gave the *In Memoriam* service. Then Dr. W. J. Carrington, Chairman of the men's arrangements also welcomed us to Atlantic City. Miss Margaret Wolfe, the new Executive Secretary, was introduced, and told us all about the Central Office which has been established in Chicago. Miss Wolfe is well fitted for her position, having been secretary to a doctor for twelve years before accepting this position. Action was authorized at this session to take out a five hundred dollar fire insurance policy for this office. It was also decided that the Auxiliary Archives would remain at the American Medical Association's headquarters rather than move them to our own office, as on occasion the Association members need to refer to them. The rest of the meeting was taken up by the reports of the various national chairmen. These will be published in the *Bulletin*, and I will not bore you with repetition.

At noon the meeting adjourned for luncheon, which was served in the Rutland Room. Upon entering, everyone was presented with a gardenia. During lunch, we were entertained by a baritone soloist. Mrs. Mosiman presided, and regretted that Dr. Lahey, American Medical Association President, who was to speak to us, was unable to attend. Dr. W. W. Bauer, of Chicago, whom many of you had the pleasure of hearing when he was in California this Spring, gave an interesting talk on *Health Education*. He said: "The whole country has but one purpose—to win the war; and the health of our country has the most essential bearing on this purpose. It is not true that we are physically soft. Not only can our Youth take it, but they are showing they can dish it out. Draft rejections do not show the health status of our country—there are many reasons for rejections that are not remedial, such as color-blindness, near-sightedness, etc. Our nation is healthier than it ever was before; we have a lower death rate and an increasing health consciousness because we know more." Dr. Bauer congratulated the Auxiliary on the splendid work that has been done with *Hygeia*. He cautioned us, however, to remember that we are not magazine salesmen, for *Hygeia* is not really a magazine; we are health teachers when we advocate its use.

Mrs. Augustus S. Kech, former National President of the Auxiliary, was the next speaker. For the past three and a half years she has been head of Health Education in the State of Pennsylvania. She started out by sending surveys to the various sections of the State, finding out how much money was being spent on health. In one community of 150,000, there were eighty-nine health organizations having no direction from a physician. Out of these, thirty-one were using their money to buy glasses for the needy, most of these cases being sent to

an optometrist. Pennsylvania has a law that furnishes glasses free to the needy upon a statement from an accredited physician that they are necessary. To show them they were doing unnecessary work and to convert these well-meaning organizations, was a simple thing. During Mrs. Kech's régime, there have been thirteen thousand meetings throughout the State addressed by accredited physicians. One thousand seven hundred and ninety-nine subscriptions to *Hygeia* have been allocated to the public schools, and *Hygeia* is used as the text book in all hygiene classes. I am repeating this so you can see what really remarkable things, we, as doctor's wives, can do.

The next speaker was Dr. R. K. Packard, who is Chairman of the National Physicians' Committee. This committee was formed by the American Medical Association to combat what may result in Socialized Medicine after the war is over. It was pointed out that the Selective Service may lead to Socialized Medicine. During these trying times, our soldiers must be given medical care, as must the communities where the Selective Service has not left enough doctors to take care of the people. In Washington today, there are two factions: one for Socialized Medicine and the other against it. As time goes on, we shall hear more concerning this.

Tuesday afternoon, a conference for State Presidents was conducted by Mrs. John L. Bauer, National Organization Chairman, and Mrs. Frank Haggard, incoming President. Mrs. Haggard stated that the aims and projects for this year would remain the same as last: Nutrition and Health Defense.

At eight that evening, the Auxiliary was invited to attend the opening session of the American Medical Association's Convention. Only those of you who have seen the Convention Hall in Atlantic City can realize how impressive this session was. The world's largest organ is in this Hall and the program opened with music. The vastness of the Hall is most overwhelming.

The next morning, the second session of the Woman's Auxiliary was held in the Vernon Room, with Mrs. Mosiman presiding. Two-minute reports were given by the State Presidents, from which some new and constructive ideas were derived. Then came the election of officers, and as there were nominations from the floor, a secret ballot was taken. Due to the length of time this procedure consumed, the meeting was adjourned until after luncheon.

The Wednesday luncheon was held in the Rutland Room, the speaker's table being decorated with orchids. All Board members were presented with gardenias. The guest speakers were: Dr. Fred Rankin, President-Elect of the American Medical Association, who congratulated us on our organization; Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association*; and Dr. Charles Gordon Heyd, member of the Board of the National Physicians' Committee, who again impressed upon us the importance of this committee. Following the luncheon, we reconvened for the election and installation of officers.

Thursday morning at ten, Mrs. Frank Haggard presided at the post-convention board meeting. Here again the aims for the year were discussed, with many helpful suggestions from the State Presidents and National Officers. As I had to leave for New York, I was unable to attend the dinner for members and guests held that evening. All the business sessions were over by Thursday noon.

May I express my appreciation for having had the privilege and honor of being sent by you, the members of the California Medical Auxiliary, to the Convention at Atlantic City? It was an experience I shall never forget.

Very sincerely yours,

LEONE LINDEMULDER.

In Memoriam

Mrs. Philip Schuyler Doane

Members of the Medical Auxiliary will be grieved to hear of the death of Mrs. Philip Schuyler Doane, in Pasadena, on June 26.

Mrs. Doane served as State President of the Auxiliary for the year 1934-35. During her term, the office of Editor was instituted and the compilation of the Auxiliary history was begun. Mrs. Doane gave generously of her ability and time to every phase of Auxiliary work, and at the close of her year as President, donated the Doane Membership Cup to the Auxiliary. Besides serving her county and state Auxiliaries in an official capacity, she was active in the national organization.

At the time of her death, Mrs. Doane was co-chairman of the Civilian Defense Council's Health and Welfare Committee in Pasadena, and a member of the Board of Directors of the Pasadena Red Cross Chapter.

The Woman's Auxiliary has lost a loved and valued friend.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (32)

Alameda County (2)

Edward S. Maloney, *Oakland*

A. L. Teeter, *Oakland*

Butte-Glenn County (2)

Fred D. Baty, *Stirling City*

Clare N. Reese, *Chico*

Fresno County (2)

Evelyn F. Buchheim, *Fresno*

Evelyn M. Ross, *Fresno*

Humboldt County (1)

Nathan Wasserman, *Eureka*

Los Angeles County (3)

A. S. Gough, *Los Angeles*

J. W. Hopkins, *Glendale*

John C. Jones, *Los Angeles*

Orange County (1)

Nicholas E. Bailey, *Orange*

San Diego County (3)

James O. Clayton, *San Diego*

J. E. Giovanazzi, *San Diego*

C. L. Jackson, *San Diego*

San Francisco County (8)

Reynold J. Ferrari, *San Francisco*

William H. Gardenier, *San Francisco*

Lewis I. Grodsky, *San Francisco*

Dorothee M. Guttentag, *San Francisco*

Harrel Lee Harrington, *San Francisco*

George T. Lenahan, *San Francisco*

Ann Louise Martin, *San Francisco*

Elizabeth A. Murphy, *San Francisco*

Santa Barbara County (3)

Wm. D. Evans, *Santa Barbara*

†For roster of officers of component county medical societies, see page 4 in front advertising section.

Walter C. Graham, *Santa Barbara*
Donald G. Holcomb, *Santa Barbara*

Sonoma County (6)

Raimond F. Clary, *Santa Rosa*
Gordon H. Congdon, *Santa Rosa*
Martin Hutchinson, *Sonoma*
Aubrey J. Nunes, *Sonoma*
Frank P. Swire, *Sonoma*
Thomas A. Ward, *Sonoma*

Stanislaus County (1)

Sidney Schwartz, *Ripon*

Transfers (2)

Elizabeth W. Tock, from Orange County to San Joaquin County
George E. Webster, from Sonoma County to Los Angeles County

In Memoriam

Burroughs, Paul Revere. Died at Santa Monica, July 1, 1942, age 60. Graduate of the State University of Iowa College of Medicine, Iowa City, 1906. Licensed in California in 1924. Doctor Burroughs was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

Fortson, Gordon Russell. Died at San Francisco, July 12, 1942, age 54. Graduate of Stanford University School of Medicine, 1923. Licensed in California in 1923. Doctor Fortson was a member of the Lassen-Plumas-Modoc County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

Larner, Thomas Edward. Died at Dobbins, July 4, 1942, age 59. Graduate of the University of Vermont College of Medicine, Burlington, 1907. Licensed in California in 1920. Doctor Larner was a member of the Yuba-Sutter-Colusa Medical Society, and the California Medical Association.

✱

Nelson, Clyde Vincent, Jr. Died at Jackson, Wyoming, June 19, 1942, age 31. Graduate of the University of Southern California School of Medicine, 1935. Licensed in California in 1935. Doctor Nelson was a member of the Los Angeles County Medical Association, and the California Medical Association.

✱

Perry, Joseph Raymond. Died at Lake Almanor, July 7, 1942, age 52. Graduate of the College of Physicians and Surgeons, Los Angeles, 1914. Licensed in California in 1915. Doctor Perry was a member of the Los Angeles County Medical Association, and the California Medical Association.

An absolute diagnosis is dangerous: it closes the avenue to further thinking.

The diagnosis must fit the facts like a glove.

All diagnoses are provisional and subject to change without notice.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939.....	1,220
March, 1940.....	9,322
September, 1940.....	17,398
March, 1941.....	24,107
June, 1942.....	39,137

After several months of preparation, C.P.S. is now intensively at work converting the entire full-coverage membership of 40,000 over to the limited surgical and two-visit deductible contracts. Any move affecting so many people, and involving so considerable cost to C.P.S. had to be planned carefully, in terms of public relations and objectives.

The work of conversion was started in the San Francisco area, beginning with the worst groups. To date, some 4,000 persons in San Francisco have been contacted and are in process of being converted. Everywhere, C.P.S. representatives have met with complete understanding on the part of beneficiary members, that abuses of the service must be curtailed in the interest of preserving a satisfactory physician-patient relationship. The decision to make this change is the result of evaluating recorded data of three years' experience.

To solve the problem of low compensation to the physician and abuse of the service by beneficiary members required the consideration of many factors. The Board of Trustees of C.P.S. had the following problems to solve in offering a new contract:

1. A contract that would automatically control abuse.
2. Coverage sufficiently broad to provide adequate medical care.
3. Cost appeal to the lower income groups.
4. Coverage and cost able to stand competition with insurance companies.
5. A contract requiring a minimum of administrative expense.
6. A sufficient scale of dues to provide income, in relation to use of service, to return a unit at par value to the medical profession.

C.P.S. is confident that the limited surgical and two-visit deductible contracts will answer these six points.

As the program of conversion proceeds from San Francisco to Alameda and Los Angeles, and then to the rest of the State, the unit value, already on the upswing, will show further improvement. The entire job will take not less than six months, nor more than a year.

* * *

(COPY*)

CALIFORNIA PHYSICIANS' SERVICE

A Non-Profit Corporation

153 Kearny Street, San Francisco

July 9, 1942.

Dear Doctor:

Recently criticism was expressed by the Alameda County Medical Association regarding some phases of

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

* This is a copy of a letter sent to some professional members who had resigned. Reprinted here for the information contained therein.

the C.P.S. plan. Carefully recorded experience in the C.P.S. office during the past three years confirms the need for change. The major faults in the old plan were: (1) Low return to the doctor for his services to beneficiary members; (2) Abuse of "full coverage" by a minority of the beneficiary membership.

To correct this, C.P.S. is transferring all "full coverage memberships" to two-visit deductible or surgical contracts. One hundred and seventy groups, or approximately 4,500 members, are actually in process of transfer in San Francisco County, and we are starting on Alameda groups next week. The entire job of converting 1,500 groups in the State will take not less than six months. It will be done district by district, taking the worst groups first. As this conversion progresses, the unit value, already on the upswing, will show further improvement. We believe the unit will reach par under this new plan.

By requiring the member to pay the doctor's "private patient fee" for the first two visits in each separate illness, we will automatically reduce abuse of service.

So far, in this process of conversion, we are finding a complete understanding and acceptance on the part of beneficiary members of the need for this change in order to preserve a satisfactory physician-patient relationship. However, the groups in Alameda County are naturally uncertain about the continuing availability of medical care in Alameda, and will continue to be uncertain unless the medical profession expresses confidence in C.P.S. The individual physician can be of great assistance by giving a word of encouragement when inquiries are made.

The incident we have gone through in Alameda County, while unpleasant at the time, has undoubtedly had a constructive effect. It acted as a stimulant that caused widespread discussion throughout the State. The recommendations of the study committees, appointed by the C.M.A., have resulted directly in the changes now in process in C.P.S.

Your resignation as a Professional Member of C.P.S. was forwarded to us as a part of the official action of the Alameda County Medical Association. Inasmuch as your County Society has rescinded its action, and in view of the changes being made in the C.P.S. plan, we understand that these resignations are withdrawn and that these names should be placed again upon the list of active members of C.P.S. Would you please confirm this by signing and returning the enclosed postcard to this office.

Very sincerely,

A. E. LARSEN, M. D.,
Secretary-Medical Director.

* * *

San Diego Doctors Pool Resources to Guard Health of War Workers

Re: Linda Vista Project

On June 30 the California branch of the medical profession completed the first two months of successful experiment in coöperative service in the San Diego area which may have a profound effect both upon the outcome of the war effort and the profession's place in that effort. Importance of the experiment, which may be extended to other parts of the state, is emphasized by California's preëminent place in the national war picture with about \$6 billion in war contracts comprising aircraft, ships and military and naval installations.

Early this spring public health authorities began to take action to prevent spread of epidemics in congested national health centers. Attention was centered on San Diego which received the largest influx of defense workers. The United States public health service had been given the responsibility of providing necessary medical care and public health facilities. It was stated emphatically that this would be done through their own personnel if other plans could not be worked out.

California Physicians' Service, largest coöperative medi-

cal organization of its kind in the United States and comprising about 5000 of the 7000 medical men of California, and offering full coverage medical and hospital care to workers in the lower income brackets, accepted the challenge. Representatives of the CPS, envisioning the possibility of government medicine starting in California, went to Washington and conferred with the United States public health service and the federal housing authority. A basic plan was worked out and approved by Washington officials, and presented to the San Diego County Medical Society and approved by that body. A special committee of San Diego physicians was appointed to work with CPS.

On May 1, 1942, operation of the plan began at Linda Vista project, San Diego. At that time there were about 3000 families or 12,000 individuals housed there. Medical needs have been met through the efforts and machinery of the local medical profession which will have control at all times. Some 20 per cent of the families signed up in less than six weeks.

Here's what the defense worker and his family living in Linda Vista received from private practitioners for \$60 a year: complete medical and surgical care, with limitations on chronic conditions in adults; a waiting period of ten months for obstetrics. Nothing is barred. In addition the family receives hospitalization in coöperation with the hospital service of Southern California. This service is limited to 14 days and partial payment on obstetrical cases after ten months' waiting period.

In the near future the national housing agency will construct suitable facilities on the project which will be rented to CPS. Temporary quarters are occupied at present. The organization employs full time physicians, subject to the approval and under the direction of the local county society committee. They work in the medical center caring for ordinary illnesses, but refer the more serious cases to local physicians.

Development of similar programs to meet the need for medical care in the rapidly expanding national defense centers of the state will relieve overworked local physicians and at the same time reduce possibilities of epidemics.—San Jose Mercury Herald, July 4.

MEDICAL EPONYM

Osgood-Schlatter's Disease

Dr. Robert B. Osgood (b. 1873), Boston, described "Lesions of the Tibial Tubercle Occurring During Adolescence" in the *Boston Medical and Surgical Journal* (148:114-117, 1903). The author made the following statements:

"The adolescent tibial tubercle, from its situation and mode of development, is susceptible to injuries, especially in athletic subjects. These lesions are usually caused by a violent contraction of the quadriceps extensor.

"Fracture and complete avulsions of the tubercle are rare, cause loss of function, and are easily diagnosed, usually clinically and always by means of the x-ray.

"Avulsions of a small portion and partial separation of the tubercle are more common. They do not cause complete loss of function, but without treatment, long continued serious annoyance. The diagnosis should be made by a combination of the clinical and x-ray pictures, and before the latter are accepted as evidence both knees should be skiagraphed and accurate technique observed."

Professor Carl Schlatter (1864), of Zurich, independently discussed "Verletzungen des schnabelförmigen Fortsatzes der oberen Tibiaepiphyse [Injuries to the Beak-shaped Process of the Upper Epiphysis of the Tibia]" in Bruns's *Beiträge zur klinischen Chirurgie* (38:874-887, 1903). A portion of the translation follows:

"There occurs, in the region of the knee, a typical form of injury, not very uncommon, whose clinical picture, in spite of all the recent advances in diagnosis, is not yet satisfactorily clear to us, as I realize from a fruitless search for a comprehensive study of this injury in the literature, and also from my own errors in diagnosis. This is the separation of the beak-shaped process of the upper tibial epiphysis, which encompasses the head of the tibia anteriorly."—R. W. B., in *New England Journal of Medicine*, Vol. 226, No. 19.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.
American Medical Association, San Francisco. Date of 1943 Session not yet decided.

The Platform of the American Medical Association

The American Medical Association advocates:

1. The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.
2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.
3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.
4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.
5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.
6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.
7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.
8. Expansion of public health and medical services consistent with the American system of democracy.

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of August, 1942:

Saturday, August 1—KFAC, 8:45 a.m., Your Doctor and You.
Saturday, August 1—KECA, 10:30 a.m., The Road of Health.
Saturday, August 8—KFAC, 8:45 a.m., Your Doctor and You.
Saturday, August 8—KECA, 10:30 a.m., The Road of Health.
Saturday, August 15—KFAC, 8:45 a.m., Your Doctor and You.
Saturday, August 15—KECA, 10:30 a.m., The Road of Health.
Saturday, August 22—KFAC, 8:45 a.m., Your Doctor and You.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Saturday, August 22—KECA, 10:30 a.m., The Road of Health.

Saturday, August 29—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, August 29—KECA, 10:30 a.m., The Road of Health.

Pharmacological Items of Potential Interest to Clinicians (From the U. C. Pharmacologic Laboratory—Chauncey D. Leake, Director):

1. *Bibliographical notes*: C. C. Thomas, Springfield, Ill., will issue C. Gemmill's *Physiology of Aviation*, as well as E. C. Hoff and J. F. Fulton's *Bibliography of Aviation Medicine*. The latter recommend a 5-foot shelf on Aviation Medicine (*Bull. Med. Lib. Assoc.*, 30:1, July, 1942). Symposium on War Medicine, edited by W. S. Pugh, published by Philosophical Library, 15 East 40th St., New York. Dr. J. G. Yoshicka, 600 20th St., N.W., Washington, D. C., performs a loyal, useful service in issuing mimeographed Far Eastern Science Bulletin, giving English abstracts of articles published only in Chinese or Japanese. The new A.M.A. symposium on *Glandular Physiology and Therapy* is out (Chicago, 1942). J. B. Neal has compiled a summary on *Encephalitis* (Grune and Stratton, New York, 1942). R. L. Kahn's *Serology in Syphilis Control*, is excellent (Williams and Wilkins, Baltimore, 1942). Burgess Publishing Co., 426 South Sixth St., Minneapolis, announces publication of F. Bernheim's *Interaction of Drugs and Cell Catalysts*.

2. *Cautions*: I. A. Mirsky and associates find protamine zinc insulin administration, too long continued, may lead to disuse atrophy of whatever pancreas tissue may be able to function, so that it is dangerous for prophylaxis of, even though beneficial in therapy of, diabetes mellitus (*Science*, 95:583, June 5, 1942). L. E. H. Whitby comprehensively discusses the hazards of transfusion (*Lancet*, 1:581, May 16, 1942).

3. *Endocrines*: Neat summary symposium on use of various hormones in general practice appears in the April *Practitioner* (148:193-218, 1942). The really excellent reviews of G. W. Thorn on desoxycorticosterone, and E. C. Hamblen on progesterone (*J. Mt. Zion Hosp.*, 8:1177, 1200, 1942) were supposed to have part of the special issue honoring B. S. Oppenheimer. C. L. Foster (*J. Endocr.*, 3:79, 1942) finds that stilbesterol implantation in immature rats causes secretory exhaustion of the anterior pituitary with cytoplasmic vacuolization. P. D. Boyer, et al. (*J. Biol. Chem.*, 143:439, 1942) show that manganese deficiency reduces growth and sexual development.

4. *Metabolism*: G. A. Alles and G. A. Feigen (*Amer. J. Physiol.*, 136:392, 1942) report that 10-40 mgm. benzedrine inhibits voluntary work fatigue, with effect greater than 10 times as much caffeine. J. S. Kirby-Smith, H. F. Blum and H. G. Grady (*J. Nat. Cancer Inst.*, 2:483, 1942) discuss ultraviolet skin radiation as a factor in carcinogenesis. C. E. Corlette describes the heat absorbing capacity of winds in relation to the human body (*Med. J. Austral.*, 1:354, Apr. 18, 1942). B. Albagli (*O. Hosp.*, 21:529, 1942) finds basal metabolic standards of Krogh more similar to Brazilian standards, which are lower than those given by U. S. writers.

5. *Sulfanilamide*: E. A. Lum (*Lancet*, 1:585, May 16, 1942) finds that sulfanilamide diffuses faster than

acriflavine or gentian violet. R. V. Hudson and R. Smith summarize several year's experience with prophylactic and therapeutic value of intraperitoneal sulfanilamide (*Lancet*, 1:437, Apr. 11, 1942). F. L. Lawson (*Amer. J. Physiol.*, 136:494, 1942) notes that sulfanilamide improves altitude tolerance of animals—as should anything that reduces cellular oxidation.

6. *Eyedeas*: W. B. Draper and R. W. Whitehead (*Lancet*, 1:442, Apr. 11, 1942) report on chances for resuscitation after overdose of ether (99 per cent), divinyl oxide (97 per cent) and chloroform (90 per cent). M. McGeorge (New Zealand), and M. Sherif and F. H. Smirk (Cairo) report on the pressor effects of S-methyl isothiurea sulfate (*J. Physiol.*, 100:474, 1942). E. J. Carey is making interesting studies on amoeboid motion of motor nerve plates (*Amer. J. Path.*, 18:237, 1942). O. C. Brantigan and J. C. Owings (Bull. Sch. Med. Univ. Maryland, 26:247, 1942) confirm S. A. Petroff's observation that detergents like Na tetradecyl sulfate enhance antiseptic action of compounds like azochloramide, and may be put in pleural cavities to clear pyogenic empyema.

Mechanism of Action of War Gases

1. Intensity of biological action of any chemical is determined by (1) dosage (mass of chemical per mass of living material); (2) ratio of rate of absorption and distribution of the drug to its rate of destruction or excretion; (3) physico-chemical properties of the drug (solubilities, polarity, molecular and energy organization, dissociation, optical properties), and (4) peculiar characteristics of individual living material involved (age, metabolic and allergic state, enzyme balance):

$$I = (f) \left[D \frac{rA}{rE} \right], C, S$$

2. War gases are related to aliphatic hypnotics and inhalation anesthetics like alcohol, ether, chloroform; they usually contain hydrocarbon groups (lipophilic), halogen (chlorine or bromine—hydrophilic) and a polarizing group (oxygen, sulphur or arsenic—proteophilic).

H-CH₂CH₂-CH
Alcohol

Cl₃C-H
Chloroform

(H-CH₂CH₂)₂O
Ether

H-CH₂CH₂-AsCl₂
Ethyl dichloroarsine

Cl₃C-NO₂
Chloropicrin

(Cl-CH₂CH₂)₂S
Mustard gas

3. Chlorine (or bromine) splits off slowly; even if some HCl is formed, buffering powers of living tissue would neutralize most of it, preventing acid injury; further, acid burns involve protein precipitation, whereas war gas injury is characterized by cellular destruction and protein hydrolysis. Molecularly intact mustard gas has been isolated from deep skin layers, after injury.

4. Configuration, adlineation, and interatomic angle forces of war gas molecules are sufficient, if enough molecules are present, to distort oil-protein-water interface, comprising cell boundary, and to rupture it, leading to cell disintegration, with consequent autolysis, inflammatory reaction, vascular breakdown, necrosis, and slow removal of necrotic tissue and gradual repair. The effects of war gases on the skin are similar to sunburn or poison oak.

5. War gas activity is reduced by acid or alkaline hydrolysis, oxidation, and adsorption; soap and water effective as detergent adsorbent; 3-5 per cent NaOCl (Clorox, Puex, Sani-Chlor, etc.) effective as oxidant; baking soda solution effective for alkaline hydrolysis; delicacy and sensitivity of mucous membranes compared

to skin requires dilution of optimum skin-effective solutions; significance of oxygen for lung injury.

6. Implications for protection and treatment: (1) air raid shelter or blackout room, doors and windows closed, for civilians; (2) for military and defense personnel, masks, goggles, oilskin or cellophane clothing, heavy rubber gloves and overshoes; (3) necessity of speedy action if contact suspected; train civilians in self-aid; dilute baking soda solution for washing eyes, nose, throat; dilute sodium hypochlorite solution on skin, followed by lots of soap and water; (4) medical management of actual war gas injury is symptomatic.—D. F. Marsh and C. D. Leake, San Francisco, May 29, 1942.

Suggested Readings on Medical Aspects of War Gas Injury

1. *General on Laws of Gases, Absorption, Asphyxia*: Y. Henderson and H. Haggard's *Noxious Gases and Principles of Respiration Influencing Their Action*, New York, 1927.

2. *High Explosive Gases*: C. K. Drinker's *Carbon Monoxide Asphyxia*, Oxford, 1938; E. J. Van Lier's *Anoxia: Its Effect on the Body*, Chicago, 1942; W. F. von Oettingen's *Toxicity and Potential Dangers of Nitrous Fumes*, Publ. Health Bull. 272, Washington, 1941; Proc. Board Chemical Warfare Service investigating disaster at Cleveland Hospital Clinic, May 15, 1929, Washington, 1929; Symposium on "blast," Proc. Roy. Soc. Med., Sect. Surg. Path., 34:171, 1942.

3. *Oxygen Administration*: A. E. Guedel's *Inhalation Anesthesia*, N. Y., 1937; T. Sollmann's *Pharmacology*, 6th ed., Philadelphia, 1942, pp. 809-818; L. Goodman and A. Gilman's *Pharmacological Basis of Therapeutics*, N. Y., 1941, pp. 677-693; A. L. Barach, J.A.M.A., 103:1690, 1934; W. M. Boothby, J.A.M.A., 113:477, 1939.

4. *Incendiaries*: J. E. Zanetti's *Fire from the Air*, N. Y., 1941; E. Fletcher and R. W. Raven's *War Wounds and Injuries*, Baltimore, 1940; A. Blalock's *Principles of Surgical Care: Shock and Other Problems*, St. Louis, 1942; C. P. Wakeley, *War Burns and Their Treatment*, Practitioner, 146:27:1941; E. W. Godding and H. E. Notton's *Phosphorus Burns*, Brit. Med. J., 1:433, Apr. 4, 1942. A. B. Wallace's *Treatment of Burns*, London, Oxford, 1941, is excellent. So is H. N. Harkins' volume, published by C. C. Thomas, Springfield, 1942; see also his article in J.A.M.A., 119:385, May 30, 1942.

Merck & Co., Rahway, N. J., will send mimeo brochure *Treatment of War Injuries: Wounds, Burns, Shock, Poisoning by Gas* (April, 1942) to any physician.

5. *General on War Gases*: OCD Manual *Protection Against Gas*, Washington, 1941. *Medical Manual of Chemical Warfare*, 1st American edition, Brooklyn, 1941—a reprint and not so well done, of a 1918 British manual. *Detection and Identification of War Gases*, 1st American Edition, Brooklyn, 1941—unsatisfactory reprint of 1918 British manual. *Treatment of Casualties from Chemical Agent*, Technical Manual 8-285, War Dept., Washington, 1941 (with subsequent revisions).

The best all around volume on the medical aspects of war gases, including psychological, is Curt Wachtel's *Chemical Warfare*, Chemical Publishing Co., Brooklyn, 1941, ix + 310 pp.

E. B. Vedder's *Medical Aspects of Chemical Warfare* Baltimore, 1925, remains a classic.

A. A. Fries and C. J. West's *Chemical Warfare*, N. Y., 1921, is not so hot.

A. M. Prentiss' *Chemicals in War*, New York, 1937, is most comprehensive.

6. *Chemistry*: M. Sartori's (trans. by L. W. Marri-son) *The War Gases*, N. Y., 1940.

7. *Pathological Effects*: The Great Classics are F. P. Underhill's *The Lethal War Gases*: Physiology and Experimental Treatment, Yale, 1920, and M. C. Winternitz's *Pathology of War Gas Poisoning*, Yale, 1920. Still sound is the Medical Research Committee's *Atlas of Gas Poisoning*, London, 1918. Important are H. L. Gilchrist's *Residual Effects of Warfare Gases*, U. S. Printing Office, Washington, 1933. A. S. Warthin's *Medical Aspects of Mustard Gas Poisoning*, St. Louis, 1919, is dated. British reports in 1919-1920 issues of J. Roy. Army Med. Corps; German data in Z. ges. expt. Med., 1921.

Calling attention to additional pharmacological items of potential interest to clinicians:

1. *Confirmations*: Yale surgeons S. C. Harvey and J. S. Gardner confirm Californians C. Gurchot and N. D. Mellars (*Science*, 92:516, 1940) that diethylene glycol is useful for heat sterilization of sharp instruments (*Yale J. Biol. Med.*, 14:547, 1942). Yaleman L. L. Langley and R. W. Clarke confirm Californians G. Girrogossintz and E. S. Sundstroem (*Proc. Soc. Exp. Biol. Med.*, 36:432, 1937) that low atmospheric pressure puts increased demand on adrenal cortex (*Yale J. Biol. Med.*, 14:527, 1942). Watch for Sundstroem's monograph (*Univ. Calif. Memoirs*, in press).

2. *New Books*: Stimulating "must" is *The Scientific Attitude* (\$0.25 Pelican Book, issued by Penguin Series, 41 E. 28th St., N. Y., 1942) by Cambridge geneticist C. H. Waddington now interested in scientific basis for ethics. This brochure covers relations of science to history, art (all phases), communism and religion. Harvard Press announces late R. Schoenheimer's *Dynamic State of Body Constituents* (\$1.75), worthy companion volume to Salter's *Metabolism of Iodine and Drinker's Lymphatics*. Timely is T. Lewis' *Pain* (MacMillan, N. Y., 1942). Also R. D. Gillespie's *Psychological Effects of War on Citizen and Soldier* (Norton, N. Y., 1942). Doubt the wisdom of reprinting out-of-date, hide-bound, "official" British War Office Manuals revised (poorly) from ideas of 25 years ago—such as *Memoranda on Medical Diseases in Tropical and Sub-Tropical Areas*, and *Medical Manual of Chemical Warfare* (Chemical Publishing Co., Brooklyn). These compound confusion of thought, perpetuate antiquated ignorance, and by means of fascist anonymity dodge criticism. Our own "official" war manuals might give individual or board authorship to assure responsibility. Present system of anonymous officiality tends to establish a canon of scientific thought, with which to differ is heresy. Editorial boards of scientific and medical journals often act as self-appointed guardians of the *canon*, happily hunting and condemning what they think to be heresy, sometimes without reading it!

3. *English Carry On*: W. W. C. Topley's Croonian (Sadlerian) Lecture on the Biology of Epidemics appears in May, 1942 *Proceedings of Royal Society* (B; 130:337). Sulfamethazine, dimethyl derivative of sulfadiazine, is said by D. W. Macartney, (*Lancet*, 1:639, May 30, 1942) to be ten times as soluble as sulfadiazine and thus not as likely to cause renal damage, whereas it is equally effective in pneumonia, meningitis, and gonorrhea. J. M. Barnes (*ibid.*, p. 531, May 2) finds 1 per cent cetyltrimethylammonium bromide ("Ctab") an excellent skin and instrument antiseptic. S. Alstead proposes charcoal filled blanket for deodorizing discharges (*ibid.*, p. 669, June 3).

4. *So Do the Australians, Swedes, Indians and Swiss*: T. E. Wilson's detailed study of Bone Marrow in Anemia (*Med. J. Austral.*, 1:513, May 2, 1942) suggests (editorially, p. 530) consideration of refractory anemia so well described by R. R. Bomford and C. P. Rhoades

(*Quart. J. Med.*, 10:175-281, 1941). M. Morrissey offers (*ibid.*, 1:543, May 9, 1942) important discussion of measurement of cardiac output by CO₂ method. Errors in calculating cardiac output are discussed by A. Aperia (*Acta. Physiol. Scand.*, 3:235, 1942). G. Hevesy and L. Hahn study ion permeability with radio tagging (*ibid.*, pp. 123 and 193). E. Nyman surveys atropine derivatives (*ibid.*, Suppl., x). B. Emilsson reports (*ibid.*, p. 335) bee venom reverses adrenalin action, but not ephedrin or benzedrin. The 3 Chopras discuss positive correlation of cannabis sativa to mental disease and crime in India (*Ind. J. Med. Res.*, 30:155, 1942). They also note strong digitalis action of cereberin, a glucoside from *Cerbera Odollam*. P. Decker gives an excellent analysis of post-operative complications (*Helvet. Med. Acta.*, 9:81, 1942). R. T. Meyer notes adrenalytic action of benzylimidazole (*ibid.*, 8:18, 1941). F. Verzar reviews function of adrenal cortex (*ibid.*, Beihefte).

5. *Endocrinology*: The big names contribute well to the June, 1942 issue, dedicated to R. G. Hoskins. M. R. Castex reports on hyperglycemic factor in normal, diabetic and pregnant urine (*Bol. Acad. Nac. Med. Buenos Aires*, Oct., 1941, p. 380).

6. *Eyeopener*: H. R. Rosenberg's *Chemistry and Physiology of the Vitamins*, (Intersci. Pub., N. Y., 1942) is superbly organized and documented, including patents.

American Physicians' Art Association: Prizes to California Physicians.—The fifth annual exhibition of the American Physicians' Art Association was held June 8-12, 1942, at Atlantic City, N. J., in Convention Hall, under the same roof with the American Medical Association.

This exhibition was enthusiastically acclaimed as most attractive, as evidenced by the fact that the 40' x 60' room was filled with visitors at all times. There were 350 original art works, a large number considering war time. Seventy-three prizes were awarded. Under the new rules, no artist may receive more than one award in one year. One of the interesting developments of the exhibition was that physicians returned again and again, bringing along friends and families. In many instances, doctors' wives brought the doctors. The estimated attendance was 15,000, and it is doubtful that a single visitor to the convention missed viewing the art exhibit.

Mead Johnson & Company's ambition to make the American Physicians' Art Association self-sustaining will probably be attained when the membership reaches 1,000. The outstanding success of the 1942 exhibition has assured a firm foundation and augurs well for the future. F. H. Redewill, M. D., San Francisco, is the secretary of the Association.

California physicians who received awards include:

LIST OF AWARDS

Name	Title	Medium
Stanley Boller, M. D. Los Angeles, Calif. <i>Trophy—Medal.</i>	"Nude"	Photograph
Frederick J. Colbert, M. D. Long Beach, Calif. <i>Trophy—Medal.</i>	"Desert Moonlight"	Oil
Chelsea Eaton, M. D. Oakland, Calif. <i>Trophy—C Cup.</i>	"The Elaine"	Oil Seascape
W. K. Fisher, M. D. Pacific Grove, Calif. <i>Trophy—Special Cup.</i>	"Right Honorable Winston Churchill"	Oil
Harry S. Fist, M. D. Los Angeles, Calif. <i>Trophy—Gold Key.</i>	"Expressions"	Wood Carving (Avocado Seeds)
S. R. Monaco, M. D. Los Angeles, Calif. <i>Trophy—A Cup.</i>	"Sgraffits Vase"	Ceramics

F. H. Redewill, M. D. San Francisco, Calif. <i>Trophy—A Cup.</i>	"The Sentinels"	Oil
John Tavlopoulos, M. D. San Francisco, Calif. <i>Trophy—Medal.</i>	"Roses"	Oil
Paul E. Wedgewood, M. D. San Diego, Calif. <i>Trophy—Gold Key.</i>	"Sealskin Satin Bowl"	Ceramics

National Foundation for Infantile Paralysis: Awards for U. C. and U. S. C.—Checks totaling \$325,844.25 have been forwarded to 26 institutions in various parts of the United States and Canada to carry on virus and after-effects research work and education in the fight against infantile paralysis, according to an announcement made by the National Foundation for Infantile Paralysis, Inc.

The National Foundation for Infantile Paralysis, Inc. leads, directs and unifies the fight against infantile paralysis by means of its research, epidemic and educational programs. It also provides medical, nursing and hospital care and orthopedic appliances for needy victims of the disease through its more than 2,400 Chapters.

The funds which make possible the Foundation's programs are raised annually in January during the various celebrations of the President's Birthday.

The California grantees and the amount of each grant follow:

For After-Effects Research

University of California, Medical School, San Francisco, California, \$5,050.00.

University of Southern California, School of Medicine, Department of Anatomy, Los Angeles, California, \$890.00.

Announcement of a five year, \$300,000 grant to the Johns Hopkins University, Baltimore, for an intensive and long time study of the disease of infantile paralysis was recently made.

This is the largest single grant made by the National Foundation since it was organized in 1938. It will be used to establish and conduct the Center for the Study of Infantile Paralysis and Related Viruses at the Hopkins.

Consultants on O.C.D. Blood and Plasma Program.

—Under the program recently launched by the Medical Division of the Office of Civilian Defense (O.C.D.) and the U. S. Public Health Service to provide plasma for the treatment of civilians injured in warfare, regional consultants have been appointed to advise hospitals on technical problems related to the establishment of blood and plasma banks.

Dr. Emeric Dobos, Senior Surgeon (R), U. S. Public Health Service, is on active duty in the Ninth Region (address: 1355 Market Street, San Francisco). The blood and plasma bank program is at present confined to vulnerable areas within 300 miles of the ocean and gulf coasts. The Subcommittee on Blood Substitutes, Division of Medical Sciences, National Research Council, serves in an advisory capacity to the Medical Division of the Office of Civilian Defense as it does to the Medical Departments of the Army and Navy and the American Red Cross.

National Foundation for Infantile Paralysis: Awards to Stanford University.—Four additional grants totaling \$20,220.00 for the purpose of providing

scholarships and training in the field of physical therapy—a field very important in the care of infantile paralysis—have been announced by the National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York.

The list of awards, including the purposes, the institutions and the amount of each award, follows:

Stanford University, California—\$5,000.00. To provide fifty scholarships for properly qualified students in physical therapy.

School of Health, Stanford University, California—\$6,920.00. To provide training in physical therapy for additional students.

Since last May, the National Foundation for Infantile Paralysis has awarded grants totaling \$347,564.25 to carry on its research and educational programs.

O.C.D. Urges Recruitment of More Nurses' Aides.

—The Civilian Mobilization Branch of the Office of Civilian Defense (O.C.D.) recently issued a memorandum to its regional representatives urging a concerted effort to stimulate the recruitment and enrollment of Nurses' Aides so as to relieve the serious shortage of nursing personnel in hospitals.

A report dated June 20 showed that 25,905 Nurses' Aides had been enrolled, of whom 12,890 had been certificated. This is only one-fourth of the 100,000 set as a goal at the beginning of the campaign in the summer of 1941. Reports from all parts of the country indicate that the training has been well carried out and the Nurses' Aides are now giving valuable service in their assignments.

The memorandum reveals that some hospitals are reported to be accepting volunteer workers without training and permitting them to carry out many of the tasks usually performed by Nurses' Aides. Although several different types of volunteer assistants can be used in hospitals, untrained workers should not be assigned to duties similar to those of trained Nurses' Aides. Such a practice militates against the establishment of a reliable, disciplined corps of workers and deters enrollment of Nurses' Aides, it was said. . . .

Without the assistance of large numbers of Nurses' Aides to supplement the registered nurses, many hospitals report that they would be unable to provide adequate nursing services. If coastal and industrial cities should be subjected to enemy attack, the need for Nurses' Aides will be greatly accentuated. The goal of 100,000 trained Nurses' Aides must be reached, the Medical Division declares. In no other branch of service can women be of greater value to the war effort.

American Congress of Physical Therapy.—The

American Congress of Physical Therapy will hold its twenty-first annual scientific and clinical session September 9, 10, 11 and 12, 1942, inclusive, at the Hotel William Penn, Pittsburgh, Pa. The annual instruction course will be held from 8:00 to 10:30 a.m., and from 1:00 to 2 p.m. during the days of September 9, 10 and 11, and will include a round table discussion group from 9:00 to 10:30 a.m., Thursday, September 10. The scientific and clinical sessions will be given on the remaining portions of these days and Saturday morning. A new feature will be an hour demonstration showing technique from 5:00 to 6:00 p.m. during the days of September 9, 10 and 11. All of these sessions and the seminar will be open to the members of the regular medical profession and their qualified aides. For information concerning the seminar and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

Pacific Association of Railway Surgeons.—The annual convention of the Pacific Association of Railway Surgeons, which was scheduled to be held in Portland, August 14-15, 1942, has been cancelled. Members of the Association will be notified in case other arrangements are made.

Award of Geiger Medal in School of Medicine of Tulane University.—The Department of Tropical Medicine of Tulane University, New Orleans, Louisiana, has announced the award of the Geiger Medal for an outstanding thesis in the field of Public Health and Sanitation to Miss Grace Ivanhoe, a native of Oakland, California. She discussed in her thesis the epidemiology of amebiasis in St. Vincent's Infant Asylum in New Orleans. The conclusion was reached that poor personal hygiene on the part of children was an important factor in its spread. As a causative element, poor personal hygiene might also be applicable to prisons and mental hospitals.

American College of Physicians Will Hold Its 1943 Session in Philadelphia, April 13-16, 1943.—The American College of Physicians has announced its 27th Annual Session to be held in Philadelphia, Pa., April 13 to 16, inclusive, 1943. Heretofore, the college has held a five-day session, but in the interest of conserving time and expense of its members, the program will be condensed into four days, Tuesday through Friday. Dr. James E. Paullin, Atlanta, as President of the College, will have charge of the program of General Sessions and Lectures. Dr. George Morris Piersol, Philadelphia, as General Chairman, will be responsible for the program of Hospital Clinics, Panel Discussions, local arrangements, entertainment, etc. The general management of the session and technical exhibits will be handled by the Executive Secretary, Mr. E. R. Loveland, 4200 Pine St., Philadelphia.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Every Eligible Physician Should Be a Member

Medical organization at this time especially, must be strong in numbers, active and alert. Therefore, every eligible physician in every county should be encouraged to affiliate with his county medical society, the State Association and the A.M.A. If there is a physician in your county who is not a member but should be one, please see him and inform him of the advantages of joining.—The Ohio State Medical Association *Bulletin*.

* * *

Rodent Control Measures in Typhus Fever Cases

The Rodent Control Division upon being notified by the Division of Epidemiology of a case of Typhus Fever, immediately dispatches inspectors to the patient's home address and also to his place of business. These premises are thoroughly trapped. All rodents caught are tagged with red tags which give the address where caught. They are delivered to the Rodent Control Laboratory where the red tags call attention of the laboratory technician to the fact that the rodents came from a typhus infested area. The rats are combed for ecto parasites.

Intensive trapping is carried on for approximately two blocks in all directions from the focal points, after which the entire neighborhood is thoroughly serviced with poisoned baits in order to kill any rodents that have escaped the trapping. Insanitary conditions (such as uncovered garbage cans, accumulated trash, lumber piled directly on the ground, etc.) are ordered abated. After this work has been completed the Rodent Control rat-proofing inspector is then assigned to these districts to order any ratproofing that may be required.—*Bulletin of Los Angeles City Health Department*.

Doctor's Wife Has Big Role In Wartime

Meet the doctor's wife.

She's playing an increasingly important part in World War II.

With more and more of the Nation's doctors being called into service with the armed forces, whole communities find themselves turning to the doctor's wife for counsel, comfort and help.

In Arkansas, where draft rejections because of malnutrition have been abnormally high, doctors' wives are mapping a victory program for the duration—and after.

Mrs. L. G. Fincher, president of the American Medical Association Auxiliary in that State, plans to make the work of her organization raising the nutritional standards of her state. She says:

"A doctor's wife always has a busy life, but now she must get busier. There are many ways in which she can serve her community, and helping people to understand the basic principles of nutrition.

"Helping the community to stay well through better nutrition is a job cut out and waiting for the doctor's wife."—*Oakland Tribune*, July 11.

* * *

You Can Help Your Country By Donating Your Blood

Many of our splendid young Americans, heroes in foreign lands and on all the seas, are suffering from wounds and giving their blood in defense of the people at home. It is difficult, far from the fields of conflict, to realize how much they are doing for us.

Here, we in our peaceful, protected San Mateo county cities can do something easy, practical and without cost to help them, perhaps to save the lives of some of them—something to surely save the lives of many of us in the event of a serious enemy raid on these shores.

That "something" is the donation of blood at the San Mateo County blood bank or the Red Cross, a mere pint from each individual so helping.

Already there has been generous, patriotic response to the appeals of the bank management and of the Red Cross, but hundreds of donations are still needed.

Believing that the hesitation of some people may be due to a feeling that the extraction of a pint of blood may entail some slight danger or that the process may be painful, the Times made an investigation in regard to that yesterday, talking with Mrs. T. J. Hanzlik, secretary of the blood bank, and with the doctors and nurses. . . .

Here are a few bits of information for persons contemplating donations of blood:

The extraction of the blood is not painful.

It is not injurious.

It is helpful in many cases.

Blood is constantly being destroyed in the body and new blood being made.

These statements have been obtained from the doctors for the assurance of citizens inclined to be timid about offering their aid.

Persons donating blood must be between the ages of 18 and 60 and not under 115 pounds in weight, with blood pressure not below 100. Minors are required to present written permits signed by their parents. Mothers with infants under nine months old will not be accepted.

Dr. James F. Rinehart, in charge of the laboratory of the blood bank, states that 1000 units of plasma are needed, with about a third of that number on hand.

You can give your blood, a little of it, for your country—amid the horrors of battle but with comfort as well as perfect safety during a pleasant half hour in the exceedingly interesting blood bank established by the citizens of San Mateo county, or to the mobile unit of the Red Cross. The thing to do is to dial San Mateo 3-1424 or call at the bank, 25 South El Camino Real, for an appointment, or watch for the dates the Red Cross mobile unit visits your community.—*San Mateo Times and Leader*, July 10.

* * *

Pomeroy Health Library Dedicated

Dr. John L. Pomeroy who served as health officer of Los Angeles County for more than 20 years assembled a public health law library which has grown from a few volumes to more than 3500 works on public health subjects. On June 24th, county officials, doctors of medicine, friends and co-workers of Dr. Pomeroy met in the building occupied by the Los Angeles County Health Department and dedicated the library to the memory of the late health officer, naming it the Dr. J. L. Pomeroy Memorial Library. Dr. Pomeroy died March 24, 1941 and this growing library will stand as a fitting memorial to this efficient and valiant public health worker.—*Weekly Bulletin of California State Board of Public Health*.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Malpractice; Sufficiency of Evidence; Qualifications of Physician Testifying as Expert Witness

A recent decision of the California District Court of Appeal, First Appellate District, *Pierce v. Paterson*, 50 A.C.A. 606, presents in a malpractice action two questions of some interest to physicians and surgeons, namely, (1) what evidence is sufficient to require the presentation of a malpractice case to the jury for decision, and (2) what qualifications must a physician possess in order to be competent to testify as an expert witness in such an action.

The case of *Pierce v. Paterson* involved an appeal from an order granting a new trial after judgment for the defendant in a malpractice action against a physician. The plaintiff in the action contended that her son had died as the result of the defendant's negligent treatment of a finger injured in a home accident, the son having caught his finger in the door of the bathroom, severely injuring it. In answer to the call of plaintiff, the defendant treated the wound by lifting the injured nail, squeezing tincture of merthiolate underneath it, and then packing the finger in metanin jelly and bandaging it. This treatment in substantially the same manner was continued for several days, when the boy developed symptoms of a tetanus infection. The patient, on advice of another physician, was taken to the Alameda County Hospital where an antitoxin was immediately administered. The boy failed to respond to the treatment, and died the next day as a result of the infection.

After hearing the testimony on both sides, the case was submitted to the jury and a verdict was returned for the defendant. On motion of the plaintiff, the trial court granted a new trial, and on appeal from this order granting a new trial, it was necessary for the Appellate Court to pass upon the sufficiency of the evidence which the plaintiff must adduce before he is entitled to have the specific issue, of whether defendant's negligence has resulted in injury, presented to the jury, and also to pass upon the qualifications of the witness, Dr. Ruedy, who testified on behalf of the plaintiff.

The court reiterated the well-established rules of law that a physician and surgeon, in undertaking the treatment of a patient, cannot be held to guaranty the results of his treatment, but that he is bound to possess the degree of skill and learning ordinarily and usually possessed by physicians and surgeons practicing in the same locality, and is also bound to use reasonable and ordinary care and skill in administering medical and surgical treatment to the patient. On trial of the case, it was plaintiff's contention that the defendant physician had failed to use reasonable and ordinary skill in caring for the injured finger and, as a result of such failure, the boy had died. More particularly, plaintiff contended that the defendant had failed to use ordinary and reasonable care and skill, in that he had not properly cleansed and sterilized the wound, nor had he administered tetanus antitoxin. In support of this contention, the plaintiff presented the testimony of Dr. Ruedy, a physician practicing in Alameda County, as an expert witness. (For a more complete consideration of the requisite qualifications of an expert witness in a malpractice action, see the Medical

Jurisprudence article in the December, 1941, issue of CALIFORNIA AND WESTERN MEDICINE, where a California case was examined in which this same physician had testified on behalf of the plaintiff.) In the words of the Court:

"Dr. Ruedy, a physician and surgeon called by the plaintiff, testified that under the circumstances of the case 'the use of reasonable medical care and skill by the attending physician demanded a thorough cleaning of the sutured finger and to give the finger free access to the air to overcome any anaerobic tetanic germs'."

The Court said that where the evidence presented tends to show that the alleged negligence resulted in an infection producing death, it presents a case for the jury. Further, the Court held that from the "expert testimony" set forth above, it could be reasonably inferred that the infection resulting in the boy's death would not have occurred if the wound had been properly cleaned and antiseptized. A new trial was granted after the decision of the Court in favor of the defendant because the trial judge, in his instructions to the jury, had limited the question of negligence to the failure of the defendant to administer tetanus antitoxin, and had precluded any consideration of the physician's alleged failure to sterilize.

The defendant had urged at the trial objections to the competency of the physician called by the plaintiff to testify as an expert witness on the question of what treatment a physician practicing in the locality would have administered in the exercise of reasonable medical care. The usual requirement is that the physician testifying be acquainted and familiar with the standards of care and skill ordinarily used and possessed in the locality in which the alleged malpractice has occurred, and that he be familiar with the usual methods of treating the particular injury or illness involved. The plaintiff's witness testified that he possessed this knowledge; and since his educational record and past experience so indicated the defendant physician could interpose no valid objection as to competency.

This case of *Pierce v. Paterson* again illustrates the importance of the expert testimony introduced by the plaintiff in a malpractice action. The testimony of the one physician called by the plaintiff was a very substantial factor in bringing about a decision against the defendant on this appeal from the order granting a new trial.

LETTERS†

Concerning Narcotic Regulations for Physicians Entering Military Service.

June 23, 1942.

George H. Kress, M.D.,
Editor, California and Western Medicine,
San Francisco, California.

Dear Doctor:

For your information and for the information of all physicians entering various branches of the military service, the Collector of Internal Revenue and the State Division of Narcotics Control advise that the following is the correct procedure to be adopted by all physicians entering military service with respect to their narcotic prescription books.

The office of the Collector of Internal Revenue advises that all physicians entering military service who are discontinuing private practice should report this

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

fact to the Collector of Internal Revenue and, if possible, should indicate what branch of the service they are entering and the time of entry. Communications containing this information should be addressed by the physician in the Northern California area to:

Collector of Internal Revenue,
Attention: Narcotics Division,
Federal Office Building,
San Francisco, California.

Physicians in the Southern California area should address such communications to:

Collector of Internal Revenue,
Attention: Narcotics Division,
Tenth Floor,
New Federal Office Building,
Los Angeles, California.

On receipt of such information, the Narcotics Division of the office of the Collector of Internal Revenue will place the physician on what is termed an "inactive list" for the duration of his military service. If the Narcotics Division is not so informed, physicians will be placed on the "delinquent list" and, it is stated, will encounter difficulty with the office of the Collector of Internal Revenue upon their discharge from military service.

The State Division of Narcotics Control advises that physicians should keep their narcotic prescription books in some safe depository with their other records. The books should not be sent back to the Division of Narcotics Control by the physician entering military service but should be kept for future use upon discharge from the armed forces.

Very truly yours,

HARTLEY F. PEART.

Concerning California Law Applicable to Persons Practicing Medicine Without a License.

(COPY)

Los Angeles, Calif., July 21, 1942.

Re: Peo. vs. Earle Musgrave—No. 12692 (misdemeanor).

Dear Dr. Pinkham:

The above entitled case was called for trial July 20, 1942, in Division 7, Municipal Court, City of Los Angeles, where defendant waived trial by jury, and case was transferred to Division 8 for court trial before Judge LeRoy Dawson. Defendant was found guilty, applied for probation and case was set for hearing on application for probation, and for sentence in Division 8, August 3, 2 p.m.

At the conclusion of this trial, Judge LeRoy Dawson made the following comment:

"It is one of the most unfortunate situations we have in this State, wherein a person found guilty of practicing medicine without a license, endangering the lives of human beings, cannot be charged with anything but a misdemeanor. It is shameful that a person who violates these provisions of the medical laws cannot be adjudged guilty of a felony and given more severe punishment when the situation is an aggravated one, but our State Legislature has adjudged it to be a misdemeanor."

Yours very truly,

BOARD OF MEDICAL EXAMINERS,
S. W. BROOKS, *Assistant Special Agent.*

Concerning Dangers Connected with Home Canning.

State of California

DEPARTMENT OF PUBLIC HEALTH
612 Phelan Building, San Francisco

July 22, 1942.

To the Editor:—With the increase in home canning, it is anticipated that there will be many deaths due to botulism in California this year unless an extensive educational campaign is conducted. Your assistance in this program is requested.

Enclosed is a copy of a circular letter which we are sending to the County Medical Societies, together with the leaflet entitled, *If You Eat Home-Canned Foods, Read This*—. We are eager to obtain wide distribution for this leaflet, and would appreciate your aid in any way possible. Additional copies in any quantity you desire will be supplied by this office.

We also wish to thank you for sending us the addresses of the County Medical Societies.

Very truly yours,

(Signed) MILTON P. DUFFY,
Chief, Bureau Food and Drug Inspections.

1 1 1

(COPY)

To County Medical Societies, addressed:

With the increase in home canning, it is anticipated that there will be many deaths due to botulism in California this year unless an extensive educational campaign is conducted. Your assistance in this program is requested.

Enclosed is a copy of a leaflet, entitled, *If You Eat Home-Canned Foods, Read This*—. Additional copies in any quantity you desire will be supplied from this office. Will you undertake to give this leaflet wide distribution throughout the district under your jurisdiction? 612 Phelan Building.

Very truly yours,

(Signed) MILTON P. DUFFY,
Chief, Bureau Food and Drug Inspections.

Concerning a Training Course for Practical Nurses.

SAN FRANCISCO COMMITTEE FOR SERVICE TO EMIGRÉS
(Federation of Jewish Charities)

1600 Scott Street

San Francisco, Calif., July 3, 1942.

To the Editor:—We are enclosing an outline of the Training Course for Practical Nurses.

Very truly yours,

SAN FRANCISCO COMMITTEE FOR
SERVICE TO EMIGRÉS,
SANFORD TREGUBOFF, *Secretary.*

1 1 1

A short and intensive Training Course for Practical Nurses is now in progress under the sponsorship of the San Francisco Committee for Service to Emigrés. The instructor is Mrs. Alfred Heuermann, former Assistant Superintendent of Nurses at the Johns Hopkins Hospital.

There are 20 women enrolled, most of whom have had previous nursing experience in Europe. The main object of the course is to familiarize the students with American methods of simple home nursing. The women will be qualified to go into homes where the patients require bed care but where it is not necessary to have the services of a graduate nurse.

The course started on June 16, 1942, in the Mt. Zion Hospital Nurses Home and will be completed on July 15, 1942. The services of these women may be procured through the employment department of the San Francisco Committee for Service to Emigrés, 1600 Scott Street, telephone FI 4513.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 8, August, 1917

EXCERPTS FROM EDITORIAL NOTES

Registration Fees.—Every licentiate has received a slip announcing that a registration fee of two dollars per annum has been imposed upon him by the legislature at the recent session. While this is presumably a "registration fee," it is really a tax for raising funds for the prosecution of violators of the Medical Practice act. The Board of Medical Examiners have not been able, with the funds accruing from the fines of convicted miscreants, to pursue a sufficiently vigorous campaign of elimination of quacks and others operating contrary to the law.

While the Medical Practice act is designed primarily for the protection of the public, and while any taxation for this protection should be in the nature of a public tax, we find on inquiry that it is a sound principle of jurisprudence to tax a craft whose calling requires regulation in order to carry out such regulation.

The accompanying letter from the Secretary-Treasurer of the Board of Medical Examiners will explain the machinery by which the tax is to be collected.

Board of Medical Examiners of the
State of California
Sacramento, California, July 3, 1917

Dear Doctor:

Replying to your recent inquiry, beg to advise that among the amendments passed by the 1917 Legislature was one providing for a \$2.00 registration fee payable to the Board of Medical Examiners by all holders of any form of certificate issued by this or prior boards regulating the healing-art in California.

The first payment of this fee is due January 1, 1918, and subsequently on January first of each year. Failure to pay the fee within 60 days after January first of each year automatically revokes the certificate, and a fee of \$10.00 must be paid to the Board of Medical Examiners in order to restore such certificate as may be thus revoked. . . .

The Board expects to forward a copy of the directory, to be published January first of each year, to each individual licentiate who forwards his fee as above noted.

Very truly yours,
(Signed) CHARLES B. PINKHAM, M.D.,
Secretary-Treasurer.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Tonsils As a Focus of Infection," by John Mackenzie Brown, M.D., Los Angeles, Calif.—It has long been recognized that the tonsil plays an important rôle along with many other structures of the body, as a possible site of focal infection. But it has been only during the past decade that sufficient emphasis has been laid on the relative importance of the tonsil in comparison with other focal lesions in the production of morbid processes in other locations, and general systemic diseases. The work of such men as P. K. Brown, Billings, Shambaugh, Rosenow and others, has demonstrated conclusively that many pathological conditions of obscure origin are due either directly, or indirectly, to bacterial or toxic absorption from preëxisting or active processes in the tonsil. . . .

(Continued in Back Advertising Section, Page 22)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.

Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held at Native Sons Hall, San Francisco, June 29 to July 2, inclusive.

Two hundred and twenty-four applicants reported for written examination, consisting of Physicians and Surgeons, Drugless Practitioners and Chiropractists. Several graduates of foreign medical schools were included in this list.

Some 23 hearings on citations were held, and the following changes in the status of California licentiates made:

Albert Bartlett Gray, M.D., revoked July 2, 1942;

Harold W. Lashier, M.D., revoked July 1, 1942;

Averell Hugh Owen, M.D., revoked July 1, 1942;

Walter Wayne Webb, M.D., revoked June 30, 1942;

Thomas D. Wyatt, M.D., revoked July 1, 1942;

Allan Prescott King, Drugless Practitioner, revoked July 2, 1942. In addition to the foregoing, Joseph Dumas Testa was found guilty and placed on five years' probation on terms.

The petition of Benjamin B. Armen, M.D., for restoration of his revoked certificate, was granted on June 29, 1942, and he was placed on probation without narcotic privileges.

News Items

"The State Board of Medical Examiners overstepped its powers in ruling that out-of-state persons who have diplomate certificates from the National Board of Examiners must wait one year before they can apply for a medical license in California, Attorney General Earl Warren said yesterday. In an opinion to Dr. Charles Pinkham, secretary-treasurer of the State Board, Warren said (Opinion NS-4378), the law clearly specified that the board may issue a license to holders of the national certificate with or without examination, but made no provision for one year's residence." (Sacramento Union, June 19, 1942.)

"The State Board of Medical Examiners late yesterday revoked the license of Dr. Thomas D. Wyatt of Redding on two charges of performing abortions and a charge of violating probation. Earlier the same day the Board had found Dr. Chester D. Sewall of Redding, guilty of two charges of performing illegal operations, but did not determine the penalty. Dr. Wyatt's license was revoked in 1939 on an abortion charge, but was restored a year later, and Dr. Wyatt was placed on five years' probation." (Redding Record-Searchlight, July 2, 1942.)

"The news story from San Francisco of how Michael Lee, 65, Alameda manufacturer of 'Merlek,' paid taxes on a net income of \$30,000 a year derived from the sale of his product over the last 12 years, would be funny if

(Continued in Back Advertising Section, Page 30)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

You know it's Effective
 but have you heard about the Economy of
AMNIOTIN

By packaging Amniotin in 10 cc. and 20 cc. vials we've provided a substantial saving over the cost of Amniotin in ampuls—and facilitated dosage adjustment to meet individual requirements.

These advantages have been made possible without sacrifice of activity, uniformity or stability. You can depend upon the effectiveness of Amniotin in relieving menopausal symptoms and in treating other estrogen defi-

ciency conditions...senile vaginitis... kraurosis vulvae... pruritis vulvae... and in gonorrheal vaginitis in children.

Amniotin—a highly purified, non-crystalline preparation of naturally occurring estrogenic substances derived from pregnant mares' urine—is available in ampuls for intramuscular injection; in pessaries for intravaginal use; in capsules for oral administration, as well as in the new economy vial packages.

Amniotin

A Squibb preparation of estrogenic substances obtained from the urine of pregnant mares

ECONOMY SIZE VIALS

10 cc.	10,000 I. U. per cc.
10 cc.	20,000 I. U. per cc.
20 cc.	2,000 I. U. per cc.



For literature write Professional Service Department,
 E. R. Squibb & Sons, 745 Fifth Avenue, New York



Did you know Johnnie Walker is a duet?

Johnnie Walker *has* to be two people. For the friendly gentleman identifies both 12-year-old Black Label and 8-year-old Red Label Scotch whisky. Each has the smooth, friendly flavour that brings a special feeling of satisfaction to your taste. You'll like mellow Johnnie Walker, from the very first sip.

BORN 1820 ...
still going strong



WHEREVER YOU ARE
IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDING SCOTCH WHISKY

BLACK LABEL
12 YEARS OLD

BOTH 86.8
PROOF

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8 YEARS OLD

Canada Dry Ginger
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R_x

Accuracy
Quality
Reliability

The Owl Drug Co

130 STORES ON THE PACIFIC COAST

BOOK REVIEWS

(Continued from Front Advertising Section, Page 17)

down to date; a review necessary for obstetricians to study, for investigators to use as a guide, and a "must" for all physicians who would treat pregnant women.

R. L. H.

Sex Fulfillment in Marriage. By Ernest R. Groves, Professor of Sociology, University of North Carolina, Gladys Hoagland Groves, author of "Marriage and Family Life," Catherine Groves, author of "Get More Out of Life." Introduction by Robert A. Ross, M. D., F.A.C.S., Associate Professor of Obstetrics and Gynecology, Duke University, School of Medicine, Member of the American Gynecological Society, American Association of Obstetricians, Gynecologists and Abdominal Surgeons, etc. Illustrations by Robert L. Dickinson, M. D. Cloth. Price, \$3.00. Pp. 319 with illustrations. New York: Emerson Books, Inc., 1942.

It is a question whether the volume "Sex Fulfillment in Marriage" measures up in text content to the scope of its title. The book contains some 320 pages with much discussion of topics that would be of little interest to young people desiring to know more about one of the fundamental instincts existing throughout all animal creation.

One review states that the book was written with "tact, spontaneity and innate good taste." That is its weakness, namely, too much "innate good taste."

Sex relationship as a physiologic function should be treated with more candor than is expressed in this volume, and sex fulfillment implies far greater exposition of the art of sexual intercourse than is found in what these authors have written.

THE MEDICAL RELATIONS DIVISION
OF CAMEL CIGARETTES BELIEVES THAT:

THE MOST VALUABLE
CLINICAL DATA RESULTS FROM
THE COLLECTIVE EXPERIENCE
OF PRACTISING PHYSICIANS.

THE PROFESSION IS
INVITED TO FOLLOW THIS
PRINCIPLE IN EVALUATING
THE PHYSIOLOGICAL IM-
PORTANCE OF THE AMOUNT OF
NICOTINE IN THE SMOKE
OF A CIGARETTE.

CAMEL

THE CIGARETTE OF COSTLIER TOBACCOS

A RATIONAL *Ulcer Therapy*

★ GASTRIC MUCIN GRANULES

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★ LITERATURE
AND SAMPLE
ON REQUEST

- EASY TO TAKE
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869 Folsom St. . . SAN FRANCISCO, CALIF.

THE POTTENGER SANATORIUM AND CLINIC

For Diseases of the Chest

Monrovia, California

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

CHOICE rooms and bungalows at rates ranging from \$35 per week up, including medical service, general nursing, x-rays, routine laboratory examinations, ordinary medicines and therapeutic pneumothorax.

A few accommodations as low as \$25 per week assigned on special application in selected cases.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases.

For particulars address:

THE POTTENGER SANATORIUM AND CLINIC, Monrovia, California

TWENTY-FIVE YEARS AGO

(Continued from Text Page 168)

From an Article on "The General Practitioner and the Tuberculous Patient," by Robert A. Peers, M. D., Colfax.
—Mr. President and Members of the Fresno County Medical Society: Your secretary, in his letter of invitation, requested me to speak to you upon either early diagnosis or the necessity of persistency in treatment when caring for the tuberculous. I thought it would perhaps be better to deal not only with these, but also with various other of the problems confronting the general practitioner in the treatment of tuberculosis. Because pulmonary tuberculosis is the form of tuberculosis most frequently met, my remarks will deal exclusively with this type of disease.

The patient with tuberculosis who comes to the specialist for confirmation of diagnosis or for treatment, nearly always comes referred by the general practitioner. He does not apply to the specialist first. If the general practitioner sees the patient early and is keen and capable, the patient's chances for improvement are much enhanced and his stay at the institution shortened materially. If the patient seeks advice late, or if, from faulty diagnosis, the nature of his disease is overlooked, the reverse is true. These remarks hold good for the larger number of tuberculous who will not, or cannot, secure the advantage of institutional care. Thus the great burden of correct diagnosis and the care of the tuberculous fall upon the general practitioner and not upon the specialist. . . .

(Continued on Page 24)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature



The "Catoptrum Micracosmicum" is one of the most beautiful and rarest of medical works. This volume by Johann Remmelin, published in 1619, contains fascinating anatomical drawings with superimposed sections. Only three or four copies of the book are known to exist.



Ever Since Eve woman probably has had to contend with the menopause. Only during a little more than a decade, with the availability of effective drugs—as epitomized by Theelin—has corrective medical treatment been possible.

Theelin replaces or supplements diminishing estrogenic ovarian secretion to "see the patient through" until endocrine readjustment occurs.

Hundreds of published papers pay tribute to Theelin, a pure crystalline estrogen, for meritorious service in such hypogonadal states as the climacteric, senile vaginitis, and kraurosis vulvae; and also gonorrheal vaginitis in children.

Theelin is doubly checked to assure uniform potency . . . by the laboratories of Parke, Davis & Company . . . and the Biochemical Laboratory of St. Louis University.

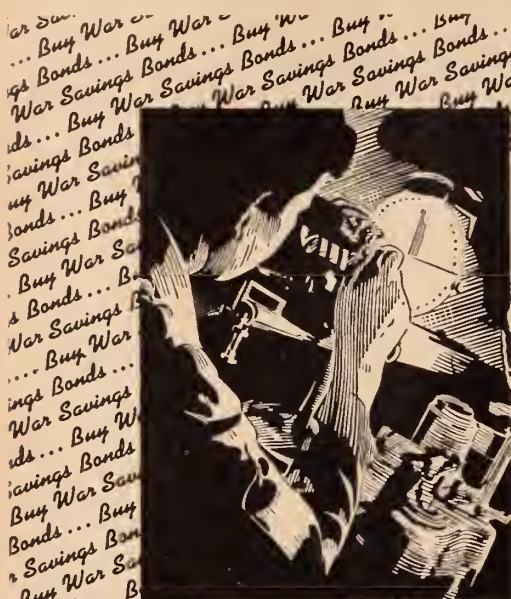
Theelin Suppositories for vaginal use and Kapseals[†] Theelol for oral administration are supplied for sustained therapy between injections and for patients who travel.

[†]Trademark Reg. U. S. Pat. Off

Ampoules THEELIN • Kapseals THEELOL

products of modern research offered to the medical profession by

PARKE, DAVIS & COMPANY, DETROIT, MICH.



"The Infinite Capacity for Taking Pains" Builds Your Reputation—and Ours

Do your patients say of you, "He is so careful about the smallest detail—he finds the exact correction for your comfort, selects most becoming style to flatter your appearance—his glasses are always so satisfactory to wear!" There is the point where too often the practitioner's reputation is lost for want of the right prescription service. It's why we take infinite pains with our work, use finest precision equipment, supply Bausch & Lomb lenses, frames and mountings.

RIGGS OPTICAL COMPANY

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

From an Article on "Focal Infection Intestinal Involvement," by F. F. Gundrum, M.D., Sacramento.—The development of a general invasion, such as septicaemia or pyaemia, from an originally localized bacterial infection has been a matter of medical observation and knowledge for many, many years. It has been but recently, however, that the relation of a once acute and now quiescent local infection to disease conditions in widely separated portions of the body has been recognized. Lubarsch has shown that a focal infection may remain dormant for a long time until some often extraneous event may bring about a new activity. The pioneer work in this field has been done for the most part by Billings, Rosenow, Davis, Jackson and others in this country. Their researches have shown that a local infection may become sufficiently chronic to cause but comparatively slight disturbance in its own neighborhood, but may still give off active bacteria or toxins to the blood stream, and produce lesions in remote structures. . . .

From an Article on "Clinical Observations of One Hundred Cases of Artificial Pneumothorax," by Ralph C. Matson, M.D., Portland, Ore.—If the ever-increasing number of contributions on artificial pneumothorax may serve as a guide, it is evident that the method is constantly obtaining more adherents; but there is still a large field open to scientific study, with many dark points to clear, and many difficult questions to solve, before pneumothorax therapy can celebrate its deserved triumph. While the method belongs to the most valuable in the

(Continued on Page 26)

Timely Hints on Immunization . . .

Diphtheria Toxoids Lederle *Smallpox Vaccine Lederle*

COOPERATING WITH THE NATIONAL PLAN of having all children over six months of age immunized against diphtheria and smallpox, public health authorities of several states are undertaking intensive drives of their own to secure the protection of a maximum number of children from these infectious scourges of childhood.

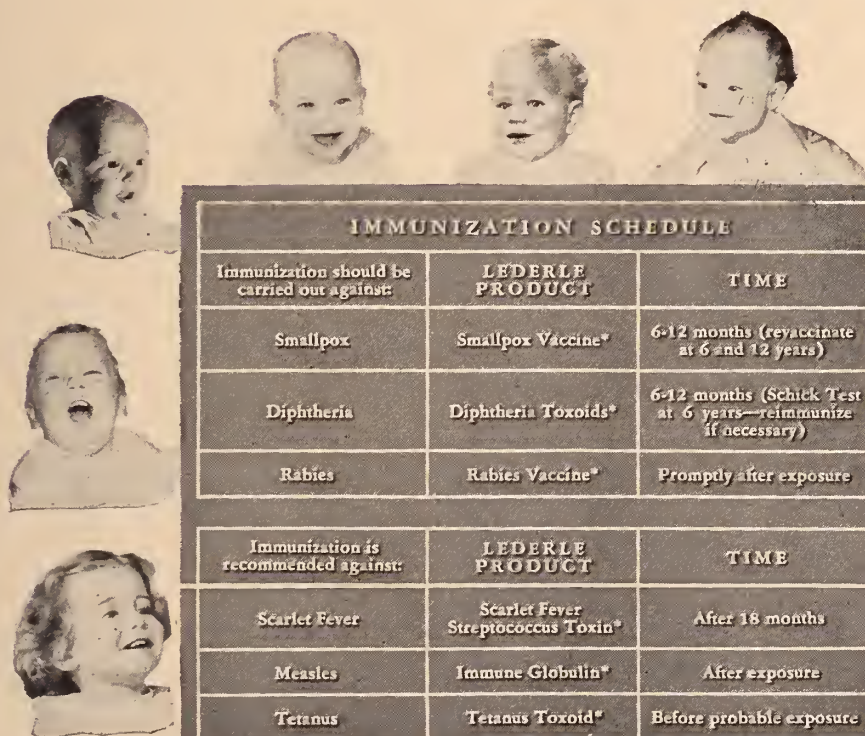
Statistics† show that there was an increase of over 1,200 cases of diphtheria in the country in 1941 over the number reported for 1940. The median for the five preceding years was almost twice the number for 1940. Let us not lose valuable ground gained—the upward trend in the incidence of diphtheria must not continue in 1942!

The method of diphtheria immunization most generally favored at present is 2 doses of alum precipitated toxoid or 3 doses of plain toxoid. In addition, the Department of Health of New York City has adopted the plan of urging that a single supplemental dose of 1 cc. of plain toxoid be given shortly before entering school to all children who have previously been immunized during infancy.

Smallpox incidence in 1941 reached a new low,† and public health authorities and practitioners should be proud of this attainment! However, 1,368

cases of smallpox were reported in 1941. Since this is a preventable disease, it is obvious that the goal has not yet been reached.

†Pub. Health Rep. 57:23,24 (Jan. 2) 1942.



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Immunization should be carried out against:	LEDERLE PRODUCT	TIME
Smallpox	Smallpox Vaccine*	6-12 months (re vaccinate at 6 and 12 years)
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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

treatment of pulmonary tuberculosis, there is no doubt that greater conservatism is being exercised, not only in the selection of cases, but in its application. . . .

From an Article on "Aims of National Food Administration."—The primary aim is to see that the people of this country eat a sufficient quantity of food, but not an excess, and that they stop waste. It is also to reduce the consumption of staples so that a large amount may be set free for export to the allies.

We wish to urge in particular the free use of vegetables and perishable foods where they are produced, to encourage the preservation of perishable and semi-perishable fruits, vegetables and other foods, to substitute other cereals to a large extent for wheat, and to reduce materially the consumption of meat.

Many other phases of the work will be developed from time to time, and reported regularly to the councils of defense.—Herbert Hoover.

From an Article on "Tuberculosis in Childhood with Unusual Manifestations," by Langley Porter, M.D., San Francisco.—The subject assigned to the speaker, tuberculosis in childhood, is obviously too extensive to be discussed in twenty minutes. It would be hopeless even to attempt a review of the literature on any subdivision of this subject, for volumes have been written on the etiology, the symptomatology, the prophylaxis, the treatment and a hundred and one of the important side issues that appeal to those who make a study of the subject.

(Continued on Page 28)



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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

In going over the last eight years' records of children who have been treated for tuberculosis at the Stanford University Medical Clinic, I have encountered a number of histories which record unusual findings, and it seemed to me that the Section might be interested in the report of the more remarkable of these. I have therefore determined to present four of these histories in some detail. . . .

From an Article on "Differential Diagnosis of Abdominal Tuberculosis," by George E. Ebricht, M.D., San Francisco, Asst. Prof. Clin. Med., University of California.—There are certain interrelations between the various forms of abdominal tuberculosis which lend themselves to brief discussion. From that standpoint it is possible to consider the several types of tubercular

peritonitis, tuberculosis of the liver and gall bladder—pancreas, spleen, fallopian tubes and ovaries, and certain forms of intestinal tuberculosis including tuberculosis of the appendix.

While primary tuberculosis within the abdomen may be conceived as possible, it is safe to assume that there are few if any exceptions to the general rule that initial tubercular lesions are of the lymphatic tissues, particularly the lymph glands, and that when tuberculosis manifests itself as peritonitis or disease of the abdominal viscera, the same rule holds true that applies in pulmonary tuberculosis: that is, that the disease is a conflagration arising from a smoldering tubercular lymphadenitis which originated during infancy or in childhood. Von Pirquet maintained, from his observations of the cutaneous tuberculin reaction, that 60 per cent of adults have or have had tuberculosis. . . .

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 168)

it were not so tragic. For it is only one more story of human hope betrayed by a trickster. This one was selling sea water under a fancy label and at fancy prices. Only conviction of violation of the food and drug act stopped him. But how about the vast harm he did by misleading thousands of sick people into the belief that 'Merlek' would cure their ills? Thus he caused them to delay seeking proper medical aid. Thus he probably is responsible for the deaths of persons who otherwise would be still alive, and perhaps happy and well again. Fortunately, the days of the patent-medicine quacks are of the inglorious past, or so it is generally understood, though this one managed to survive for 12 years. There are,

however, many other fraudulent cures of one kind and another still being offered a credulous public, that the law should attend." (San Diego Tribune, June 17, 1942.)

"Dr. John P. Mason, Redlands chiropractor, today is free of charges of having violated the state medical act, having been vindicated by a jury in Redlands justice court. The jury was out for about two hours before bringing in the verdict. State investigators charged Dr. Mason with practicing medicine and surgery without a license in treating a throat case with an electrical machine. Prosecuting was W. N. Anderson, of the State Medical Board, and Dan C. A. Smith, deputy district attorney and defendant's counsel was H. W. Dalton, Westwood. . . ." (San Bernardino Sun, May 28, 1942.)

(Continued on Page 31)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

"Dr. J. J. Tobinski, 49, and his former office assistant, J. C. Marx, 44, who pleaded guilty to a charge of performing an illegal operation in their Hill street office, today were under sentence of from two to five years in San Quentin Prison. Superior Judge A. A. Scott, who pronounced sentence, at the same time exonerated Dr. Roy L. Buffum, Long Beach physician. Prosecutors moved for dismissal, stating there was no evidence that he had any illegal connection with the other two men." (Los Angeles Herald and Express, June 17, 1942.)

"Dr. Howard M. Engle, chief of staff of Hahnemann Hospital here, was installed as president of the American Institute of Homeopathy at the close of the institute's 98th annual convention in Chicago, it was announced today." (San Francisco Call-Bulletin, June 19, 1942.)

"Echoes of a sensational case involving the break-up of a notorious illegal operations ring, which operated in an old two-story house at 1011 223rd Street in the Key-stone district, south of Dominguez Hill, came last week when the State Board of Prison Terms and Paroles fixed the term of Claude Ramsey at four years, with parole to be given when he served half the time. Ramsey was one of seven defendants in the case, and was originally sentenced June 4, 1941, in the Long Beach superior court to an indeterminate term of two to four years. The gang was headed by Mrs. Mae 'Doc' Ramsey, Claude Ramsey's mother, who went to Tehachapi for a term of from four to ten years. The raid which developed the case took place in December of 1940, when investigators from the State Board of Medical Examiners, armed

(Continued on Page 32)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 31)

with warrants issued by Judge H. Leonard Kaufman of Compton, descended on the Keystone district residence. Mrs. Esther Ramsey, wife of Claude, turned State's evidence and was placed on probation. Also placed on probation was William Crissman of Los Angeles. Also sentenced to terms of from two to five years were Marguerite Bair Green of Bellflower, daughter of Mrs. Ramsey and Lillian Foster and Grace Balch of Wilmington. Mrs. Green was not arrested in the original raid, but was nabbed by investigators as she was about to board a train for the East." (Compton *Herald-American*, June 18, 1942.)

"Dr. James F. Petrie, 33, chiropractor, today was acquitted of the abortion murder of Angelka Gogich, 18-year-old Hollywood dancer. The jury, which had been deliberating since early yesterday, came in shortly before noon today with the verdict of not guilty." (Hollywood *Citizen-News*, June 24, 1942.)

"Arthur Osborne Phillips, 47, until a month ago known as Dr. James Herman Phillips at a Chico hospital, today had pleaded guilty to a felony charge of possessing a concealed weapon and was sentenced to nine months in the County Jail. . . ." (A. P. Dispatch dated Oroville, June 30, 1942, printed Oakland *Tribune*, June 30, 1942.)

"Accused of heading a notorious illegal operations ring in Chicago, Dr. Max Gecht, owner of the Hillcrest Sanatorium at La Crescenta, and his associate, Isadore

(Continued on Page 33)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 32)

Rosalyn, must return to Illinois to face prosecution. Governor Olson yesterday granted the application of Illinois authorities for the extradition of Gecht and Rosalyn, who had submitted affidavits denying they were in Chicago at the time the crimes allegedly were committed." (Los Angeles Examiner, June 11, 1942.)

"Death of Alberta Dorothy Fisher Huffman, 22, was the result of an illegal operation, a coroner's jury decided yesterday, naming Dr. Jackson Smitherman, Negro physician of 1802½ Central Avenue, as the man responsible. The jury recommended that Merton Frye be held as an accessory. Frye testified he had been living at the same address as Miss Fisher, 1151½ E. 66th St., and that he got Dr. Smitherman to perform the operation May 22, at the Maywood Hospital." (Los Angeles Herald and Express, June 4, 1942.)

"Held to answer late yesterday for the death of Mrs. Leona Tarleton, wife of a Santa Monica defense plant employe, Dr. A. M. Tweedie of Los Angeles, today was awaiting his arraignment in the superior court on June 26. Death was due to ether poisoning, a coroner's jury decided last week. Bail was set at \$10,000, which Dr. Tweedie was unable to raise at the time he was bound over at conclusion of a preliminary hearing that occupied all of Wednesday in Los Angeles municipal court. He is charged with murder and abortion. . . ." (Santa Monica Outlook, June 11, 1942.) (Prior entries, News Items, California and Western Medicine, Dec., 1936, Aug., 1937.)

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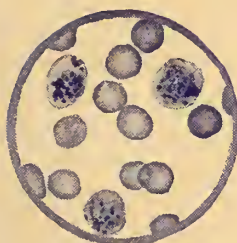
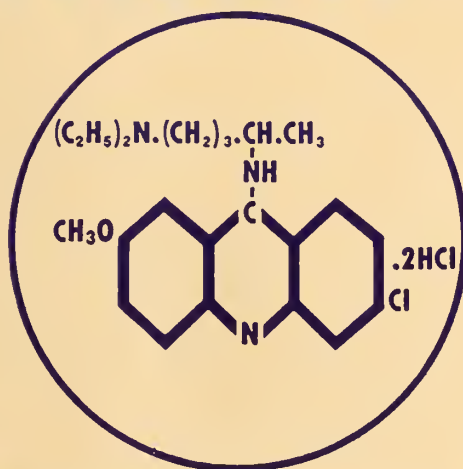
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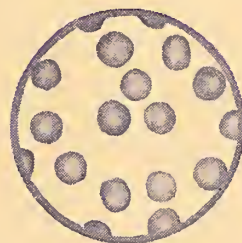
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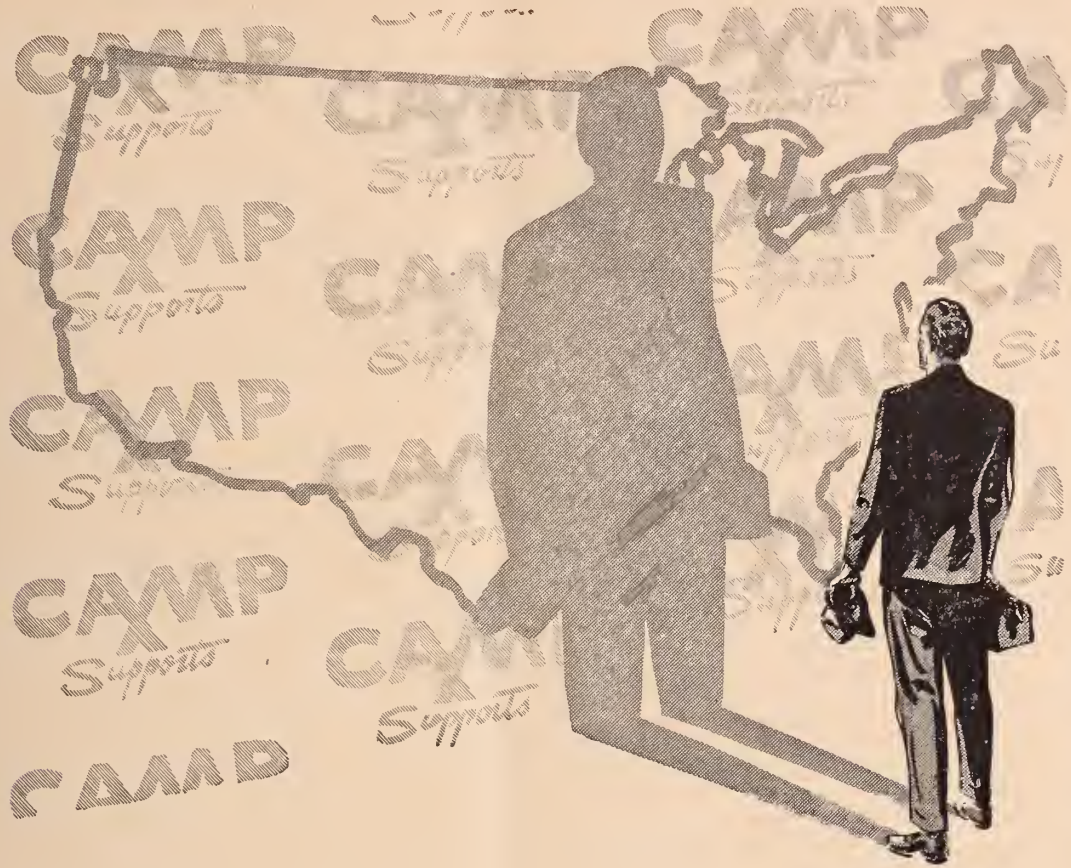
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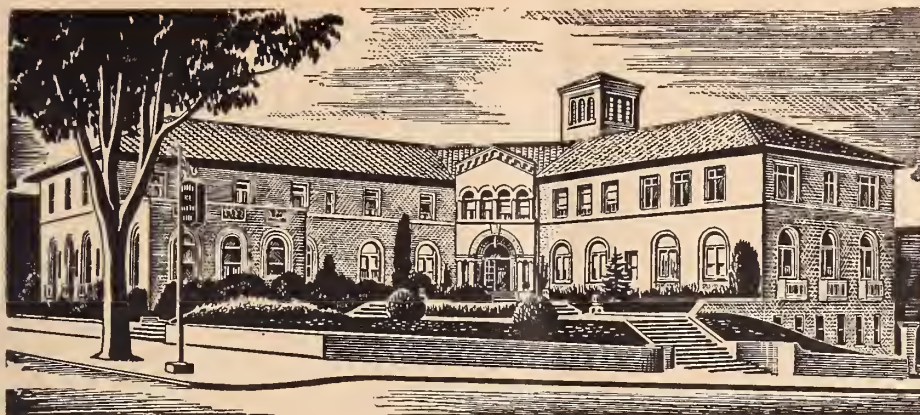
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The Care of the Aged (Geriatrics). By Malford W. Thewlis, M.D., Attending Specialist, General Medicine, United States Public Health Hospitals, New York City; Attending Physician, South County Hospital, Wakefield, R. I.; Special Consultant, Rhode Island Department of Public Health. Fourth edition, thoroughly revised with 50 illustrations. 589 Pp. Cloth. Price \$7.00. St. Louis: The C. V. Mosby Company, 1942.

War Medicine. A Symposium, edited by Winfield Scott Pugh, M.D., Commander (MC), U.S.N. Retired. Formerly Surgeon, City Hospital, New York. Cloth. Price \$7.50. Pp. 565, illustrated. New York: Philosophical Library, 1942.

Pain. By Thomas Lewis, M.D., F.R.S., Physician in Charge of Department of Clinical Research, University College Hospital, London; Fellow of University College, London. Cloth. Price \$3.00. Pp. 191, with illustrations. New York: The MacMillan Company, 1942.

Emergency Care. By Marie A. Wooders, B.S., R.N., Principal, School of Nursing, Hackensack Hospital, Hackensack, New Jersey and Donald A. Curtis, M.D., Lieutenant-Colonel, Medical Reserve, Commanding 342nd Medical Regiment, United States Army; Instructor in Military Nursing, Hackensack Hospital, Hackensack, New Jersey. Cloth. Pp. 560, with 201 illustrations. Philadelphia: F. A. Davis Company, 1942.

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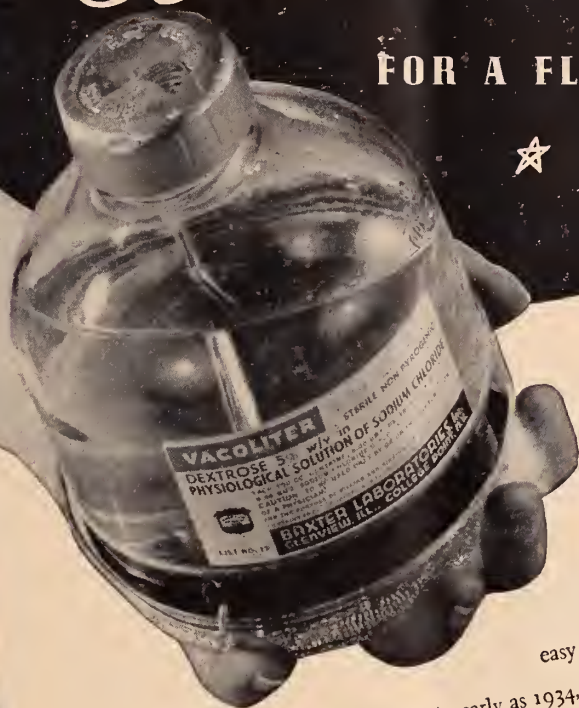


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Clinics: Symposium on Burns and Shock. (Issued bi-monthly). Vol. 1, No. 1, June, 1942. Edited by George Morris Piersol, M. D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa. Paper. Price \$12.00 per year. 264 Pp. Illustrated. Philadelphia: J. B. Lippincott Company, 1942.

Physical Diagnosis. By F. Dennette Adams, M. D., Instructor in Medicine, Harvard Medical School, Courses for Graduates, Physician, Massachusetts General Hospital. Thirteenth edition. Cloth. Price \$5.00. Pp. 888, illustrated. Baltimore: Williams & Wilkins Company, 1942.

The Mind and Its Disorders. By James N. Brawner, M. D., Medical Superintendent, Brawner's Sanatorium, Smyrna, Georgia. Cloth. Price \$3.50. Pp. 228. Atlanta: Walter W. Brown Publishing Company, 1942.

Tuberculosis Hospital and Sanatorium Directory. Compiled by the National Tuberculosis Association, June, 1942.

BOOK REVIEWS

Stedman's Practical Medical Dictionary. By Stanley Thomas Garber, B. S., M. D., University of Cincinnati College of Medicine. Cloth. Price: With Thumb Index, \$7.50 (without Thumb Index, \$7.00). Pp. 1257, illustrated. Baltimore: The Williams & Wilkins Company, 1942.

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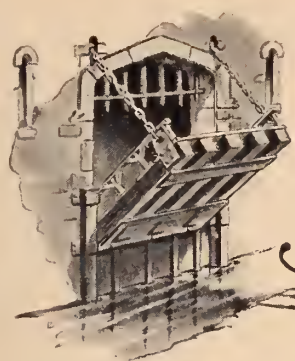
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BOOK REVIEWS

(Continued from Page 10)

balk it by interrupting the normal alphabetical arrangement with long lists of subtitles or tables breaking the continuity of the pages. Nevertheless, subtitles are sometimes necessary, and tables, as of the arteries, muscles, etc., cannot be dispensed with.

Medicine touches other sciences at so many points that the terms relating to them cannot be ignored, even in a purely medical dictionary; accordingly an effort has been made to include definitions of all the chemical, botanical, dental and veterinary words which a physician is likely to meet with in his reading.

Special attention has been paid to the etymology of the words used in medicine, for nothing aids so much in fixing a definition in one's memory as a knowledge of the formation of the term; therefore, the chief sources of medical terms in our language—Anglo-Saxon, Latin and Greek, and to a lesser extent Arabic—have been indicated under the main titles and, where necessary, under the subtitles as well.

In the spelling of these medical terms preference has been given to the simpler forms.

The terminology suggested by a committee of the Anatomical Society of Great Britain and Ireland, by way of revision of the Basle Anatomical Nomenclature, has again been included in the Appendix, together with the BNA equivalents.

Standard Nomenclature of Disease and Standard Nomenclature of Operations. Edited by Edwin P. Jordan, M. D. 1022 Pp. Chicago: American Medical Association, 1942.

The purpose of the system of classifying disease em-

(Continued on Page 16)

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BOOK REVIEWS

(Continued from Page 14)

played in this book is to present a logical clinical nomenclature. The work on this nomenclature was initiated by invitation of the New York Academy of Medicine, March 22, 1928, and at that time the National Conference on Nomenclature of Disease was formed, with a membership representing most of the leading medical and public health organizations in the country. The Commonwealth Fund was responsible for a large share of the financial support for this undertaking. A number of individuals, special funds, insurance companies and medical organizations also contributed to the support of the work.

Obviously a nomenclature of this kind must be kept constantly abreast of the progress of medicine, and the responsibility for its periodic revision was therefore taken over by the American Medical Association in 1937. The present is the third edition.

Physicians' Reference Book of Emergency Medical Service. A compilation, chiefly from medical literature, presenting the practical experience and lessons acquired in handling civilian war casualties. Paper. Pp. 268. New York: E. R. Squibb & Sons, 1942.

The Physicians' Reference Book of Emergency Medical Service is designed to acquaint physicians and surgeons in the United States with professional literature not readily available here regarding medical and surgical problems arising from the impact of modern warfare on the civilian population. It presents briefly the practical experience and lessons acquired in handling civilian casualties. It has been compiled mainly from British medical literature, but also in part from American

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 16)

sources. The subject matter relates chiefly to the manner in which ordinary civilian accident practice must be modified to deal with crush, blast, bomb and burn injuries, and resulting shock, encountered in air raids.

The Biological Action of the Vitamins. A Symposium edited by E. A. Evans, Jr., Associate Professor of Biochemistry, the University of Chicago. 227 Pp. Illustrated. Cloth. Price \$3.00. Chicago, Illinois: The University of Chicago Press, 1942.

Even though the papers gathered in this volume were planned and presented in a less critical time than that of the moment, their value is enhanced by circumstances which make information as to what constitutes optimal human nutrition of great practical importance. Currently,

the most striking advances in nutritional knowledge center about the vitamins. If we knew nothing more of these substances than their therapeutic value for such gross pathological conditions as scurvy, beriberi, and pellagra, the interest and extensive experimentation which they have evoked would be amply justified.

In recognition of this common interest in vitamins on the part of investigators in many fields, the universities of Chicago and Wisconsin joined in a Symposium on the Respiratory Enzymes and the Biological Action of Vitamins in connection with the Fiftieth Anniversary celebration of the University of Chicago.

The Reception of William Beaumont's Discovery in Europe. By Dr. George Rosen, with a foreword by Dr. John F. Fulton. Cloth. Price \$5.00. Pp. 97. New York: Schuman's, 1942.

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 18)

William Beaumont may be ranked with Benjamin Franklin and Weir Mitchell as one of three Americans whose writings exerted a profound influence upon medical thought of Europe prior to 1900. Dr. Rosen's welcome study of the reception of Beaumont's work in Europe makes it evident that Beaumont's disclosures were more fully appreciated abroad during the first years after their publication than they were in his native country. This fact in itself is not especially surprising since there were few contemporary physicians in the United States equipped to appreciate the full importance of Beaumont's use of scientific method; the medical profession, moreover, had not yet become accustomed to having important work emanate from the military services.

In retrospect, especially in wartime, Beaumont's contribution is one of challenging significance. On the basis of one well studied case Beaumont was able to change the course of medical thought in the sphere of gastroenterology. How many young physicians of the present day in our armed forces will grasp the opportunities which war will inevitably present to them? From the chaos of belligerency one must preserve anything of enduring value and Beaumont gives the inspiration of a great example.

The National Formulary. Prepared by the Committee on National Formulary by Authority of the American Pharmaceutical Association. Official from November 1, 1942. VII edition. 690 Pp. Published by the American Pharmaceutical Association, Washington, D. C., 1942.

The National Formulary is revised under the direct authority and supervision of the Council of the American

(Continued on Page 21)

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BOOK REVIEWS

(Continued from Page 20)

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One of the earliest problems of the Association was found to be the standardizing of formulas for unofficial preparations which were being used by physicians, and many of which, while intended for practically the same purposes, varied in unimportant characteristics or proportions. The multiplicity of preparations which differed in nonessential proportions of constituents, or in colors or flavors, burdened both the pharmacist and the physician, and some method of standardizing such preparations by a recognized authority was needed.

The present is the Seventh Edition of the National Formulary. The first edition appeared in 1888, at which time the following statement was made concerning the book: "Your committee is convinced that it only expresses the unanimous sense, not alone of the members of the Association, but of all progressive and fair-minded pharmacists throughout the land, that there is and shall be only one standard as to quality and strength to be followed for all official preparations, viz., the United States Pharmacopoeia; and that, therefore, the National Formulary—which is, at most, intended only as a stepping-stone from and to that authority—is a standard only for those preparations which are not provided for by this official work; and further, that from the moment when the United States Pharmacopoeia shall provide a formula, or a standard for any article or preparation now or hereafter contained in the National Formulary, the authority of the latter regarding this article or preparation ceases and is abolished."



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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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EDITOR GEORGE H. KRESS

Committee on Publications

George W. Walker (Chairman) Fresno 1943
F. Burton Jones Vallejo 1944
Francis E. Toomey San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of
California Medical Association department. (For page
number see index below.)

Advertisements.—The Journal is published on the seventh of
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fifteenth of the month preceding issue. Advertising rates will
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Volumes begin with the first of January and the first of July.
Subscriptions may commence at any time.

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both the old and the new address. No change in any address on
the mailing list will be made until such change is requested by
county secretaries or by the member concerned.

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Contributions—Exclusive Publication.—Articles are accepted
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Contributions—Length of Articles: Extra Costs.—Original
articles should not exceed three and one-half pages in length.
Authors who wish articles of greater length printed must pay
extra costs involved. Illustrations in excess of amount allowed
by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND
WESTERN MEDICINE has prepared a leaflet explaining its rules re-
garding publication. This leaflet gives suggestions on the prepa-
ration of manuscripts and of illustrations. It is suggested that
contributors to this Journal write to its offices requesting a copy
of this leaflet.

DEPARTMENT INDEX

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EDITORIALS

ON SENDING MEDICAL JOURNALS TO PHY- SICIANS ATTACHED TO STATION HOSPI- TALS OF ARMY AND NAVY CAMPS IN CALIFORNIA

A Request for Coöperation Addressed to Physicians in Civilian Practice

**Publicity Concerning Military Equipment is
Censored.**—Military regulations relating to
publicity concerned with Army, Navy and Air
Force camps forbid the publication of informa-
tion that could be of use to enemy forces. In the
subject here to be discussed, it is therefore not
possible to give detailed data concerning Army
and Navy camps in California or other Pacific
Coast States.

It is permissible to state that many Army, Navy
and Air Force camps are in active operation in
California, each possessing its full complement of
medical officers, in a ratio of about 6 or 7 physi-
cians to every 1000 men. For an index, it need
only be remembered that California's quota of
physicians who are to go into the armed forces by
the end of the year 1942 has been estimated to be
2600, as already stated in Colonel Seeley's letter,
printed on page 2, of the July issue of CALIFOR-
NIA AND WESTERN MEDICINE.

* * *

**Colleagues in Military Service Discontinued
Subscriptions to Medical Journals.**—Members
of the California Medical Association who are in
civilian practice at the present time are requested
to remember that when local colleagues recently
entered service with the armed forces, it was
practically necessary for most of these physicians
to give up medical journal subscriptions—be-
cause, even if the publications were continued,
there was no assurance of delivery of such second
class mail, since the continental and overseas
assignments of physicians to station hospitals and
camps are being changed with great frequency.

As a consequence, in some camps the amount
of medical literature in evidence is so small that
many of these physicians, with more time than
usual on their hands—after routine military
duties have been performed—are practically
starving for publications that could keep them in
touch with current medical progress.

* * *

**How Can Military Colleagues Receive Medi-
cal Publications?**—Such being the facts, what
are the measures which can be instituted and
through which, the conditions may be improved?

The procedures outlined below are submitted by the C. M. A. Committee on Postgraduate Activities since, under existing conditions—owing to the many extra demands on teachers and other speakers—the refresher courses, heretofore arranged for county societies and districts, are now no longer available.

* * *

The Plan for Supplying Literature—In More Detail.—The proposed plan comprehends the contribution of medical publications by physicians in civilian practice, after they, themselves, have had an opportunity to read the journals—using for the collection of material, the three medical libraries of California (U. C.; Stanford; Los Angeles County Medical Association), as the major collection and distribution centers.

Hospital libraries and county medical societies can participate in the work by collecting journals from staff and society members, and forwarding such—as *fourth class mail, or if more than eight ounces, via parcel post*—to one of the three library depots mentioned above.* It is believed that donation of magazines will be given by physicians.

After receiving the material, the libraries of the three institutions will carry on, according to arrangements made with the C. M. A. Postgraduate Committee; the California Medical Association covering the postage and incidental expenses involved in forwarding the literature. Further comment concerning these details may be here omitted.

In each month's issue of CALIFORNIA AND WESTERN MEDICINE—in the department, "Committee on Participation of the Medical Profession in the War Effort"—will appear a "reminder item" to members of the California Medical Association, to continue the contribution of medical journals.

* * *

First Steps in This Plan of Coöperation: How Members, County Societies and Hospital Staffs Can Aid.—To create a beginning for this work, an appeal is herewith made to members of the California Medical Association to look over the medical journals received since January, 1942 that yet remain on their shelves, with the view of forwarding many such to one of the three library depots.

Request is also made that the President or Secretary of each county medical society, and the chief or librarian of each hospital staff call the attention of their respective groups to this effort to be of service to confreres now in military service. Coöperative endeavor on the part of every hospital staff or county society member is solicited.

Certainly, what is asked is little enough, in the way of appreciative token, to indicate to our fellows who are in the armed forces that physicians still at home keep them in mind; and that

they are willing, at least in small degree, to give expression to their kindly thought.

If the plan, as above outlined, does not fit in with the convenience of some readers, then such members are to feel free to send the medical journals to the C. M. A. Postgraduate Committee, 450 Sutter, San Francisco, where the Association Secretary will be glad to follow on.

* * *

Little Enough is Being Requested.—Readers are requested to visualize how they would feel if they were suddenly thrust from busy civilian practices and environments into service with the armed forces—with much strange routine procedure of a military nature, but little or no medical literature to keep them abreast on newer work, or facilities to maintain contacts with civilian practice.

Certainly what is here asked is little enough on the part of those of us who still remain at home. However, if that little to us means much to our colleagues who have already answered the call of our Country, we, who yet remain behind, must not be found wanting.

* * *

The Plan: In Recapitulation.—To summarize:

(1) Check over your medical journals (CALIFORNIA AND WESTERN MEDICINE included), and send them to one or other of the three medical library depots whose addresses have been given in a preceding footnote, or to the C. M. A., at 450 Sutter, San Francisco.

(2) If such procedure is not convenient, ask your county medical society or your hospital group to do this for you. For convenience of members, have your hospital group place a box, properly labeled, for such journals in the staff reception room.

(3) From month to month, and from now on, or until other notice is served, keep up this good work. It is important. By so doing, you will have the consciousness of knowing, in small part, at least, that you have backed up your good and kindly words to colleagues who are in military practice, by a practical expression of real interest and aid.

* * *

Military Colleagues Will Again Return to Civilian Practice.—Do not forget: These colleagues will be coming back to us again, one of these days, to start all over in the task of building up of private practices. Let us, each and every one of us, do our bit, in making that day of return more hopeful for our brothers at the front, than it may, at times, to them, seem to be.

A well trained physician, who keeps alert, will always be able to make a place for himself.

We owe it to these California and other colleagues who are in military service, that we aid them in keeping themselves in touch with medical progress and practice.

Reader, your help in this will contribute toward that end.

You are counted on to do your part!

* Addresses of the California Medical Libraries:
U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.
Lane Medical Library, Clay and Webster Streets, San Francisco, California.
Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

ON VARIOUS TOPICS

California's Proposed Basic Science Law,
Proposition Number 3

Candidates for the State Legislature

Female Employees in Physicians' Offices—Welfare
Commission Hearing on Wage SchedulesChauncey D. Leake of U. C. Medical School Goes to
University of Texas Medical School"Parergon," Meaning "Work by the Side of Work"—
100-Page Brochure Portraying the Artistic
Creations of Doctors of Medicine

Proposition Number Three: Basic Science Initiative—Its Purpose and Scope.—In the July issue of the OFFICIAL JOURNAL, on pages 4 and 100, and in the August number, on page 153, comment was made concerning the proposed initiative law that, in one sense, is only an addition to the licensure statutes of the three healing-art groups recognized in California—(1) non-secularians or regulars; (2) osteopaths, and (3) chiropractors—the attention of members of the California Medical Association being called to the heavy obligation resting on every physician to educate his lay fellow citizens on the need of such a law, and to vote YES thereon at the November 3d State election.

The justification for the law, now being proposed, rests on the simple proposition that human health and life are little less than sacred; and that it should be a fundamental obligation of every commonwealth to safeguard its citizens from incompetent or poorly-trained practitioners of the healing-art, no matter to what group they may belong.

The proposed initiative law is not retroactive; it does not imperil in any way the status of healing-art practitioners who are already licensed by the State of California, nor will it, in any manner, interfere with the right of a citizen to call into service the healing-art practitioner of his own choice.

The basic science education demanded—in anatomy, physiology, biochemistry, bacteriology and pathology—can be acquired from any source whatsoever; that is, in any healing-art school or liberal arts college or university, or through private or self-instruction.

The certificate to show that an applicant for a healing-art license has passed the Basic Science Board examination need not be obtained prior to entering a healing-art school; but can be secured at any date prior to taking the healing-art examination proper, that is, even at the end of his healing-art course. Ample time, therefore, is given to acquire this basic education.

Licensure is mandatory for many professions and vocations.—For many occupations and professions, the State has laws to determine whether the individuals, who desire to pursue such, have had sufficient education and other training to indicate that they would be persons to whom could be safely entrusted the responsibilities involved.

If standards of education, then, are set for

plumbers, architects, and other groups, surely, as regards human health and life, the State, having a very special obligation to protect its citizens from incompetent practitioners of the healing-art, must be at liberty to establish similar standards for the practice of medicine.

Basic Science laws, now existing in some sixteen commonwealths and the District of Columbia, are a means to that very end. The objective is most worthy.

Physicians must inform patients and friends.—The Basic Science Initiative (Proposition Number 3) will be on the November 3d ballot and will be approved by the electorate; *provided*, the Doctors of Medicine now practicing in the State of California will educate their patients and friends on the desirability of this beneficent measure.

The above thoughts were indicated, perhaps in other words, in the comments which appeared on page 4 of the August CALIFORNIA AND WESTERN MEDICINE, and are again presented because of their great importance. Since these wartimes bring about unstable conditions, it is difficult to make forecasts, as in days of peace, especially in regard to elections. Therefore, all the more reason to be on the alert.

To repeat: Talk PROPOSITION NUMBER 3 to your patients and friends, and ask them to vote, YES, thereon.

With concerted effort, the proposed statute will be approved by the electorate. If, however, the members of the medical profession fail to actively espouse Number 3, the proposition may go down to defeat. That, indeed, would be a calamity not only for the present, but for the days to come.

Candidates for the State Legislature.—Elsewhere in this issue appears a tentative list of candidates for the California State Legislature, whose names will appear on the November 3d State election ballot.* In the minds of physicians, members of the Legislature, as a class, should be differentiated from other citizens, because State Senators and Assemblymen—with the Governor—are the law makers of the Commonwealth. If, individually and collectively, they believed in and would support legislation that makes for best promotion of the public health and the maintenance of the standards of scientific medicine, physicians could almost forget the necessity of remaining interested in the proceedings of the biennial legislative sessions. However, since experience has shown that a considerable number of Legislators may be expected to hold views not conducive to best public health conservation, it follows that Doctors of Medicine must maintain a proper orientation of what is transpiring in the legislative halls at Sacramento. In last month's issue (August CALIFORNIA AND WESTERN MEDICINE, on page 116), attention was called to the "Final Election and the Course of Action" in regard thereto. Readers who failed to note the item

* See page 224.

may wish now to refer to it. In the days ahead, up to Tuesday, November 3d, physicians have an opportunity to know who are the Senatorial and Assembly candidates from the districts in which they vote, and to learn what are the reactions of the different candidates concerning public health standards.

With such knowledge at hand, physicians should know for whom to cast their ballots.

Female Employees in Physicians' Offices: Industrial Welfare Commission Hearing on Wage Schedules.—On page 209 of this issue will be found the text of a statement presented by the Association to the Office Wage Board of the State Industrial Welfare Commission, relative to the wages and hours of female employees in physicians' offices. A letter on the same subject, from a dental colleague, appears on page 223.

The Wage Board is considering the matter of setting new maximum hours and minimum wages for female and minor employees in business and professional offices. Existing wage and hour orders of the Industrial Welfare Commission call for a maximum of 48 hours' work per week and a minimum wage of \$16 a week. What new standards may be set by the present Wage Board we will doubtless learn in the course of the next few months.

Criticism has been heard in some places of the long and irregular hours that some office employees of physicians are asked to maintain. Additional criticism has been heard of the relatively low wages paid some such employees.

The Association's statement on these matters, based partially on common knowledge and partially on a spot survey made by the central office, refutes this type of criticism. However, it must be recognized that in some medical offices the demands on office employees are considerable for the amount paid in wages. It might be well at this time, when war has added greatly to prices, when taxes on incomes and on all purchases have increased sharply, when the temptation to step into a "soft spot" at high wages is great in the minds of medical office employees, to ponder this matter.

Chauncey D. Leake, of U. C. Medical School Goes to University of Texas School of Medicine.—Chauncey D. Leake, Ph. D., director of the U. C. Pharmacologic Laboratory, has decided to accept the teaching and administrative position tendered him by the Regents of the University of Texas. What California loses through this change, will be gained by the University of Texas Medical School.

Doctor Leake has made many friends in California and his genial presence will be greatly missed in C. M. A. Postgraduate conferences, in the promotion of which he has so willingly served. The promise has been secured from him that he will continue to forward his comment on "Pharmacological Items of Potential Interest to Clinicians," which have been appearing in the Miscel-

lany department of CALIFORNIA AND WESTERN MEDICINE. Doctor Leake has the good wishes of California friends as he takes up his new work in the Lone Star State.

"Parergon," Meaning "Work by the Side of Work": A 100-Page Brochure Portraying the Artistic Creations of Doctors of Medicine.—Physicians who have received copies of the Mead Johnson & Co. brochure from the Condé Nast Press, portraying oil, pastel, water color, sculpture, photographic and other artistic efforts of members of the medical profession, must have been surprised at the large number of contributors from California. For the information of CALIFORNIA AND WESTERN MEDICINE readers, a list of the California physicians whose names appear on "Parergon" is given in this issue, on page 219.*

An interesting foreword and other comment appears on the covers of the brochure. Many of the 96 pages contain as many as six illustrations of different types of work by medical artists. If special reference is permissible, it would be to mention the illustration of the sculptured head of the late Joseph Pomeroy Widney, M. D., who was the motivating spirit in the group of founders of the Los Angeles County Medical Association.

That the work of some seventy-five California physicians is shown in the illustrations should be a legitimate source of pride for C. M. A. members. At the Coronado annual session and at Del Monte, some two years ago, the California Physicians' Art Association presented displays. For several years, artist members of the Los Angeles County Medical Association have held annual exhibits. These comments are made to congratulate the colleagues whose names appear elsewhere, and who have exhibited their artistic efforts in the displays referred to. It is to be hoped the good work will continue.

The following paragraphs, from the foreword in "Parergon" should be of interest:

"Reverting to the introductory expressions of astonishment and delight at the capabilities of the contemporary physician in the realm of the fine arts, these may be explained, apart from the traditional background, by the fact that he deals with that most exquisite form of divine art and beauty, the human body.

"The same skill that makes the surgeon's fingers deft with scalpel and ligature is at work in the exquisite sculpture and carving represented in this book. The eye that so quickly and accurately evaluates differences in color and texture between normal and pathologic tissue coordinates the hand that wields the painter's brush.

"The man who is attracted by medicine as his life's work is largely motivated by a love for his fellow man, else he would choose a vocation offering greater monetary reward. He starts with, or very early acquires, keen observation, manual dexterity, constructive imagination, sympathetic understanding, philosophy and reverence, all of which are the very essence of art."

* "Parergon" has been brought off the press by Mead Johnson and Company of Evansville, Indiana. The brochure gives the address of the American Physicians' Art Association as Flood Building, San Francisco, Francis H. Redewill, M. D., Secretary.

EDITORIAL COMMENT†

DUPLEX ANTIGENS

Data, suggesting that a single protein molecule may stimulate the production of two qualitatively-different circulating antibodies, are currently reported by Smadel¹ and his coworkers of the Rockefeller Institute.

It was shown by Tanaka² and Freyer,³ in 1902-4, that vaccine lymph gives specific flocculation reactions with vaccinia-immune serum. Two soluble antigens were afterwards demonstrated in this lymph⁴: a heat-labile (L) antigenic fraction readily destroyed at 56°C., and a heat-stable (S) fraction resisting heat to 95°C. By cross-absorption tests, Cragie⁵ afterwards demonstrated that the same L- and S-antigens are also present in vaccine elementary bodies. There was suggestive evidence that the L- and S-antigens are conjugated, in the elementary body, to form a single protein complex, the so-called "LS-antigen," which is capable of reacting equally well with L- and S-circulating antibodies. It was suggested by Smadel and Rivers¹ that the serologically-active parts of this hypothetical protein conjugate (LS) undergo a series of independent degradations, giving rise to such fractionally-denatured complexes as L'S, L''S, LS', L'S', etc.

This theory of the nature of the natural antigen in elementary bodies is currently tested on vaccine dermal filtrates by the Rockefeller biochemists. Dermal pulp, from cutaneously infected rabbits, was extracted in a 1:50 dilution of standard phosphate buffer solution (pH 7.2). The extract was afterwards freed from cellular debris by centrifugation, followed by Seitz filtration. Electrophoretic analysis of the resulting filtrate demonstrated the existence of four distinct protein fractions. Fractionation was effected by altering the pH of the filtrate, by which means the dermal proteins were separated into three overlapping groups: A, proteins which remained in solution at pH 4.63; B, proteins precipitated at pH 4.63, but soluble at pH 6.31; and C, proteins precipitated at pH 6.31, but soluble at pH 8.56. On reprecipitation both A and C fractions were serologically inert, giving no test-tube reactions with either L- or S-antibody. The original reacting titer of the dermal filtrate, however, was found quantitatively in the B fraction. Physical and chemical studies showed this fraction to be a homogeneous protein, with a molecular weight approximately that of serum globulin. This B-protein is precipitated quantitatively with either L- or S-precipitin, from which they conclude that this natural antigen is "a single molecular substance containing both L- and S-activity."

They found that the L-portion of this native

antigen can be partially (L') or completely (L'') denatured by heat, without serological alteration of the S-portion. By means of enzymic digestion, the S-portion can be similarly degraded (S', S'') without demonstrable alteration of the L-portion. Dissociation of the LS-molecule into free L- and free S-antigen, however, was not demonstrated, the allegedly free L- and S-antigens of previous investigators presumably being L''S, LS'', or other unipolar degeneration products.

Demonstration of this duplex antigenic protein is not only a valuable contribution to the current theory of acquired immunity to vaccine virus, but is equally suggestive in numerous other infectious and allergic processes. Thus far allergists, for example, have almost invariably reasoned from the assumed one-to-one, antigen-antibody relationships of classical immunology, in spite of the reported synthesis of numerous "duplex" proteins of "hybrid" antigenicity.⁶ For a decade the "emergent evolution" of new or "hybrid" blood specificities has been of speculative interest to geneticists.⁷ The dual antigenic molecule of the Rockefeller biochemists, therefore, may also be of basic nonclinical biological interest.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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MALPRACTICE PROPHYLAXIS—MEDICAL DEFENSE*

A reduction in the number of malpractice actions can be effected only through the development of a strong defense. It is obvious that such actions would be discouraged if plaintiffs consistently failed to obtain favorable judgments.

Of course, it is not to be argued that a doctor who is actually guilty of malpractice should be allowed to go free of any penalty. There are meritorious claims, and these should be settled out of court—preferably before suit has been filed.

Unjustifiable claims, however, should be contested as thoroughly as possible. In such cases it is sheer folly to compromise, on the theory that a slight settlement would be less expensive than the cost of defense. Such a course serves as an

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

* Third of a series of articles on Malpractice Prophylaxis (Article I, in July issue, on page 7. Article II, in August, on page 121.)

encouragement to others whose claims are not justified. This short-sighted view, which is so common today, is directly responsible for the rapid increase in the number of malpractice claims in some sections of the country. If cases based upon unjust or absurd claims are permitted to receive even a slight profitable return, there will be an incentive to bring more of them.

It is a great temptation for a doctor to rid himself of these nuisance claims by making a small settlement. The unfavorable publicity, the loss of time, and the mental and emotional strain involved in defending a malpractice suit may lead the physician to compromise. But, as is so often the case, the easiest way out of a situation is seldom the best. For the sake of both himself and his colleagues, the doctor should make a determined opposition to any unjustified claim.

The task of defending a malpractice case is one which requires a high degree of specialization, as well as a peculiar aptitude on the part of the attorney. He must be able to understand the medical problem presented in each case; for it is his duty not only to conduct the examination of the case, but also to cross-examine the plaintiff's witnesses, including the medical experts. If the attorney's medical knowledge is so limited that he is unable to comprehend the significance of the testimony, the defense will be seriously handicapped. Moreover, such an attorney would be incapable of the thorough analysis of the medical problem, which must serve as a basis for the construction and development of a sound and practical theory of defense.

The task of handling medical expert witnesses is also one which necessitates specialized training. Unless an attorney possesses an understanding of the psychology of medical expert witnesses, the defendant's own witness may do more harm than good. For one thing, medical experts are often accustomed to having their opinions listened to and accepted as authoritative. They are seldom prepared to be confronted with contradiction or expression of doubt as to their judgment. In addition, the expert may be definitely opinionated; and insistence upon personal preference in medical procedure may do much to injure the case. In many instances, the experts for the defendant have not had sufficient opportunity to discuss the case thoroughly and in a group before the time comes to go into court. In such cases, minor discrepancies may appear in their testimony, even though there is no actual disagreement which is of significance. Nonetheless, any such disparity in testimony is sure to be pounced upon by the plaintiff's attorney, and the effect upon the jury may be definitely prejudicial. Obviously medical experts must be encouraged to be fair and impartial. But they must also be simple and direct, they must employ phraseology which will be understandable to the jury, and they must be able to retain complete self-control under cross-examination which may be deliberately irritating.

Far too many malpractice actions have been lost

through poor defense; this is an aspect of the problem which needs more attention, particularly in areas which have become virtual hot-beds of malpractice actions. Wherever a serious threat is made against a physician, a carefully-prepared procedure should be put into effect. Every phase of the case should be thoroughly investigated by experts. All available witnesses should be interviewed, and all records carefully examined while the case is comparatively fresh. It is particularly important that the physician or physicians who succeeded the threatened doctor in the care of the patient should be interviewed.

On the basis of all this evidence, the justice of the claim should be weighed. If the charge of malpractice seems justified, an attempt should be made to settle the case out of court. If the suit is to be fought in court, meticulous attention must be given to the method which is to be used by the defense in handling the medical facts. It is especially important that these facts be given the best possible sequential presentation. It is for this reason that the defense attorney must be equipped with a competent understanding of the medical problem involved. Far more often than not the defendant physician is too much involved emotionally to be able to give real assistance in the formulation of questions to be asked of medical expert witnesses for either side.

Through the development of a sound, capable and intelligent method of defense it will be possible to effect a reduction in the number of malpractice claims. Therefore, it would be difficult to over-estimate the importance of the way in which such claims are handled. Each step toward the formulation of better defense is a major contribution to malpractice prophylaxis.

6777 Hollywood Boulevard.

LOUIS J. REGAN,
Los Angeles.

SULFONAMIDE RESISTANCE*

For four or five years it has been known that certain bacteria are capable of becoming resistant to the bacteriostatic action of the sulfonamides, a phenomenon similar in many respects to the development of drug-fastness during the arsenotherapy of syphilis. Sulfonamide resistance, at first a test tube curiosity, is rapidly becoming of considerable importance in clinical medicine.

Experimental studies have clarified certain aspects of the development of sulfonamide resistance.¹ Resistance has been demonstrated for many organisms commonly pathogenic for man, including streptococci, staphylococci, colon bacilli, gonococci, and *Brucella*. *In vivo*, sulfonamide-resistant pneumococci have been developed by serial passage through mice, treated with less than curative doses of sulfapyridine. Organisms made insensitive *in vitro* are also resistant *in vivo*, and vice versa. Although it may be lost when only partially developed, well established resistance is apparently retained indefinitely.

* From the Department of Medicine, Stanford University School of Medicine, San Francisco, California.

In humans, sulfonamide-resistant organisms have been reported in pneumococcal pneumonia and meningitis, and recently a fatal case of type seven pneumococcal endocarditis has been reported in which the organism became highly resistant to sulfapyrazine.² Prolonged contact between the organisms and the sulfonamides seemed necessary for the development of a high degree of resistance in these cases. Insensitive strains of gonococci have been found to respond poorly to sulfonamide therapy.³ An interesting recent report from England describes wound infections in a plastic surgery ward, caused by resistant hemolytic streptococci (Lancefield Group A, type 12).⁴

Experiments of one group indicated that gonococci were capable of becoming resistant to sulfanilamide, but not to sulfathiazole; but this statement has been challenged by others, who have isolated sulfathiazole-insensitive strains from patients.³ Quantitative studies indicate that the development of sulfonamide resistance represents an interaction between the organisms and the one common structural unit of all the sulfonamides, namely the p-amino nucleus, and it seems probable that all organisms susceptible to the bacteriostatic action of the sulfonamides are capable of becoming resistant to all of the sulfonamides.⁵ It is for this reason that, in subacute bacterial endocarditis, in which prolonged therapy presumably produces a high degree of resistance, changing from one sulfonamide to another causes no beneficial effect.

The future importance of sulfonamide resistance is uncertain. However, since well established resistance is apparently retained indefinitely, it is conceivable that widespread epidemics might be caused by drug fast bacteria. The therapy of infections, due to insensitive organisms, is thus a challenging problem. It is in such situations that the new agents, penicillin and gramcidin, may find their greatest usefulness, especially in superficial infections caused by gram positive organisms. The rôle of pneumococcal serum in destroying resistant pneumococci is not yet known. These and other therapeutic problems have yet to be studied experimentally and clinically. However, from the standpoint of the practicing physician, it is important to realize that the phenomenon of sulfonamide resistance does exist, and the physician should keep it in mind, in treating patients who do not respond to sulfonamides in the usual manner.

2707 Jackson Street.
2398 Sacramento Street.

WILLIAM M. M. KIRBY,
LOWELL A. RANTZ,
San Francisco.

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Medical Aid in U.S.S.R. Army

(Continued from Page 200)

Smorodintsev and his staff have made important contributions to the early diagnosis of typhus. Other experiments include work on the sterilization of air and the production of liquid oxygen.

The world of medicine has been enriched by discoveries such as these: A soluble preparation of sulphidine, an x-ray device which facilitates the location of foreign bodies in the human organism, a synthetic oil of balsam, and a method of producing antityphus vaccine in large quantities. Other discoveries are being added constantly.

Doctors serving with guerilla detachments behind the German lines combine medical work with fighting. They have contributed this observation to the art of medicine: that the wounded who were compelled to be continuously on the move progressed more favorably than those who could follow the traditional method of enforced rest. Other surprising revelations have been set forth by Professor A. Bogomolets, president of the Ukrainian Academy of Sciences. This savant claims that man's normal life span should be about 150 years. He and his son have prepared an antireticular cytotoxic serum, small doses of which stimulate the system of connective tissue. Their theory is that the struggle for normal longevity is, in the first place, a struggle for healthy connective tissue. The serum is used for accelerating the knitting of broken bones by producing a stimulating effect on the growth of osteoplasts. Its usefulness has been proven in the treatment of delayed healing of ulcers and in combating infections.

Unfortunately, Bogomolets' interesting studies were interrupted with the sudden invasion of Russia by the German barbarians. All scientific institutions immediately reorganized their work to pursue the only purpose of all scientific institutions and all citizens of Russia, to defend their country until the utter defeat of Nazi Germany, thus contributing to the struggle for democracy for all nations whose very existence, science and culture are threatened. The years of patriotic war have shown that the medical profession of the Soviet Union is productive of bold, daring ideas and indefatigable in research.

450 Sutter.

Educational Requirements of Medical Schools

The tremendous demand for physicians made by the military forces has caused the suggestion that the educational requirements of our medical schools be relaxed, so that doctors may be produced in a shorter period of time. If that suggestion was widely followed, one result would be inevitable—a definite decline in the quality of medical service given the American people. The time required for graduation from an accredited school of medicine, coupled with the hard, continuous application required of students, is our best guarantee of adequate service. Before we lower the standards, which are low enough now, an effort should be made to solve the problem. This problem involves the health of the Americans of tomorrow, no less than of those of today.

ORIGINAL ARTICLES

Scientific and General

CLINICAL-PATHOLOGICAL CONFERENCE*

WALLACE M. YATER, M.D.

Washington, D. C.

AND

ERNEST HALL, M.D.

Los Angeles

DOCTOR GARNETT CHENEY: The meeting will come to order. It has been a long time since Richard Cabot popularized the Clinical-Pathological Conference, which became very popular and highly instructive. Perhaps it is particularly fitting in these times in its truly democratic sort of institution. At a recent conference of this type in San Francisco ten clinical experts were selected to diagnose the cases. Ten experts gave their opinions, and then discussion was permitted from the floor. An intern from one of the hospitals got up and presented a diagnosis that was quite different from that of the ten wise men, and he was the only one who was right in that conference. Now, today we don't have any ten wise men. Fortunately they are all rolled into one in the person of Doctor Wallace Yater, Professor of Medicine, Georgetown University, whom you have heard before. Doctor Ernest Hall, Professor of Pathology at the University of California has selected two cases, and will take up the discussion of pathology after the cases have been presented from a clinical point of view by Doctor Yater. Now, as in that meeting in San Francisco, every one of you will have that same opportunity to agree or disagree with Doctor Yater's diagnosis, providing you do it in silence. I will turn the meeting over now to Doctor Yater, who will carry on from here. Doctor Yater.

* * *

DOCTOR YATER: I imagine these two cases were selected on the assumption that I am a cardiologist instead of just a plain doctor. This conference will be a feat of mental gymnastics more than anything else, because I am ashamed I have to confess that I haven't been able to arrive at a diagnosis in either of these two cases; so that you are going to have a lot of fun at my expense. I have been trying to bribe Doctor Hall all morning, but he doesn't bite. I hope you have all read over these cases because then I believe you can sympathize with me. Anyhow, since I can't tell you what the diagnosis is, I am reminded of a story. An elderly man was very ill. He had lots

of consultants: ten wise men. And they went into a huddle in consultation. The patient knew that they wouldn't tell him the results of the consultation, so he had his small grandson hide in the closet in the room in which the consultation was to be held, and to listen to the consultation and to report back. After the consultation, the boy reported back and said that he couldn't understand what the doctors said, but that they stated at the end, "we will learn all about it at the autopsy." So that is the way it must be here.

In the first case, a white woman, aged 62, had apparently been pretty well most of her life until the year before she died. Now that means that we have certain things to consider from the standpoint of sex and with a patient who is in the older age group. So that limits our discussion to certain things immediately. At the time of the first examination, a year before death, she had a persistent attack of irregularity of the heart, and apparently this was auricular fibrillation. And, interestingly, an x-ray film of the heart showed no enlargement, nor did it reveal any passive congestion. So that we have auricular fibrillation in the patient without other evidence of heart disease. We know that auricular fibrillation may occur in patients without heart disease. But this patient died a year later. And, therefore we have to consider the possibility of heart disease in this case. The fibrillation came and went for several weeks, finally subsiding altogether, but without complete improvement in her general condition. I think I will go through the history and then come back and discuss the possibilities.

REPORT OF CASE

CASE 1.—S-4656. H. S. White, female, aged 62.

Past History—In April, 1939, was under care of physician in Newark, Delaware, for irregularity of the heart. This was first persistent attack of this nature although patient thought she had had mild transient irregularity for many years previously. No history of rheumatic fever. Electrocardiogram taken at that time showed auricular fibrillation but 6 foot film showed no cardiac enlargement and no passive congestion or other parenchymal involvement. Fibrillation came and went for 7 weeks, finally subsiding altogether, but without complete improvement in general condition.

In June, 1939, patient returned to her home in Detroit and was hospitalized because of recurrence of fibrillation. In the hospital the following studies were made: *Fasting sugar* .105 grams; *non-protein-nitrogen* 34.5 mgs. *Basal metabolism*—13%. *Kahn negative*. *Blood count*: Hb. 108%; R.B.C. 5.40 m.; W.B.C. 16,600; differential normal. *Urinalysis*: negative.

Electrocardiogram on three occasions revealed evidence of frank coronary sclerosis with serious myocardial damage, and on two occasions uncontrolled fibrillation was evident.

For two months, numerous drugs were used in an attempt to control the rapid fibrillation. Early in August, 1939, while still fibrillating, fluid was found in the right chest, without temperature. On the x-ray film the fluid obscured the right leaf of the diaphragm and extended up the lateral chest wall to the level of the 7th rib in the axillary line.

Note: Chest Film No. 1—Report indicated shift of

* This is the edited electric recorder transcript of the discussion of one of the cases of the clinical-pathological conference held at the second general meeting of the Section on General Medicine of the California Medical Association, May 5, 1942.

† Wallace M. Yater, M.D., is professor of medicine in the School of Medicine, Georgetown University, Washington, D. C. Doctor Yater was a guest speaker at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 5-8, 1942.

the heart shadow toward the right side with consolidation of the right lung at the hilum. No cardiac or aortic enlargement. Left lung field clear.

At about this time all medication was stopped, since the fibrillation was persistent; and the family was notified that the outlook was extremely grave.

One week later, cardiac rate and rhythm spontaneously reverted to normal; and in the subsequent weeks the general condition also became normal, with increase in weight, strength and appetite and loss of nausea, which had been present while the patient was in the hospital. Her condition was considered sufficiently satisfactory by October 24, 1939, to permit a trip to California. Her only medication was one digitalis tablet daily, and mild sedative.

Familial and Marital History—Non-contributory.

Present Illness—Patient arrived in Los Angeles early in January, 1940. Was first seen January 18, because of transient fibrillation.

Physical Examination—Pulse, 80. Respirations, 16. Blood pressure, 160/90 (not fibrillating).

A well developed and nourished woman of stated age in no apparent distress. No cyanosis or edema. No distention of cervical veins. Lungs clear. No cardiac enlargement. Between attacks of fibrillation rhythm was entirely regular. A2 greater than P2. No murmurs. No enlargement of liver, spleen or glands. During attacks of fibrillation, only slight dyspnea. No orthopnea.

Subsequent Course—On 5 grains of quinidine sulfate, t.i.d., transient fibrillation was at first controlled satisfactorily; but after several days, transient episodes occurred despite increased doses of quinidine. Complete digitalization was tried with Digilanid C, because of nausea induced by smaller doses of Digitalis purpurea, persistent fibrillation having set in at this time. In spite of much more than the calculated dose, no change in the rapid fibrillation was obtained; and after several days Digilanid was dropped to 1 cat unit twice a day, as a maintenance dose. Evidence of a small amount of fluid was present in the right chest posteriorly, but there was no edema, hepatic enlargement or other evidence of decomposition. Fluid aspirated from right chest was clear and straw-colored and without cellular elements. Dry cough, severe in nature, developed at this time and continued until shortly before death, being only slightly affected by codeine.

Hydro-Quinidine was added to the maintenance dose of Digilanid, but without effect. Anorexia and weight loss became prominent features, with weakness.

There was a gradual downhill trend until the evening of April 1, 1940, when the patient became suddenly more dyspneic, and for the first time consented to hospitalization. There was marked cyanosis and orthopnea but no cough, and the rapid accumulation of chest fluid necessitated tapping twice within 48 hours, the fluid being as previously reported. Very rapid fibrillation (160-170 per minute) persisted, in spite of administration of Mecholyd and potassium acetate and intravenous strophanthin.

The patient lapsed into coma and died April 4.

DOCTOR YATER: A note is made that there was no history of rheumatic fever. Two or three months after the onset of the arrhythmia she returned home, but shortly after she was hospitalized because the fibrillation had recurred. The laboratory studies that are listed were all normal except for a moderate leukocytosis. Electrocardiograms on three occasions revealed evidence of frank coronary sclerosis with serious myocardial damage. That, unfortunately, is the way that the electrocardiologists give us poor in-

ternists the diagnosis of the electrocardiograms. Instead of telling us what they find, what the various waves show, and so forth and so on, and letting us decide whether it is evidence of myocardial sclerosis, they try to make it easy for us, but, as a matter of fact, they only make it harder. They assume we don't know anything about electrocardiograms, which, in many cases I suppose is correct. In this case no fibrillation was evident. Of course, a good cardiologist would naturally want to see those electrocardiograms, but not being a good one, it doesn't make much difference to me.

For two months numerous drugs were used in an attempt to control the rapid fibrillation. Rapid fibrillation is apparently emphasized. Early in August, 1939, about six months or more after she began to have her troubles, as far as she knew, while still fibrillating, there was evidence of fluid in the right chest, but without any fever connected with it. And you see it apparently wasn't great in amount. A note is made that the x-ray film showed that the heart shadow shifted to the right side with evidence of consolidation of the right lung at the hilum. There was still no evidence of cardiac or aortic enlargement, the left lung field being clear. Now, inasmuch as these signs in the chest cleared up later, it is hard to know exactly what they were due to. When I first read this case over on the train coming out here, I thought of the following possibilities: A myocardial infarct; atelectasis of the right lung, of the right lower lobe perhaps (not seeing the film, I couldn't be too sure of any of these things); and perhaps a tumor of the bronchus with atelectasis and possibly the accumulation of some fluid. But we can't be particularly dogmatic about these possibilities because we don't know enough about the details.

All medication was stopped, apparently, because the fibrillation did not respond to it, and the patient this time was very ill. We don't know what the features of this illness were, so we just have to visualize a very sick patient without any other details. But one week later, strangely enough, the cardiac rhythm spontaneously became normal. It may have been that her illness was due, or appeared to be due, more to the persistence of the rapid fibrillation than to, perhaps, some more serious condition at that time. She became quite normal with increase in weight, strength, and appetite, and lost the nausea which may have been due to the medication taken while she was in the hospital.

She became well enough to come to California, where everybody is supposed to get well. In this case, though, she didn't do that. She arrived in Los Angeles early in January, which was about eight months after she became ill, and on January 18 again had transient auricular fibrillation. The pulse rate was only 80. Respirations were normal. The blood pressure was 160/90. This is the first indication of the blood pressure reading that we have had, and the patient was not fibrillating at

this time. There was some increase in the systolic pressure with slight increase in the diastolic, but a great increase in pulse pressure. That in itself does not help us a great deal, because most people around 60 have a blood pressure about like that. At this time she was well nourished and not particularly ill. There was still no evidence of heart disease, no chronic passive congestion, and no cardiac enlargement. So we are still "up in the air."

She was given quinidine and digitalized without any apparent effect upon her condition. We don't need to go into the details of this feature, because sometimes we know that these drugs don't stop fibrillation. It persists in spite of everything. Then again, a small amount of fluid was present in the right chest posteriorly, with no edema. There was no evidence of congestive failure, or decompensation. Fluid aspirated from the right chest was clear and had no cellular elements. The patient had a dry cough, severe in nature, developing apparently about this time and continuing until shortly before death, that is, she had the cough from January to April, about three or four months.

Apparently, from the time she arrived in Los Angeles she lost her appetite and lost weight. Weakness became a prominent feature. Loss of appetite and weight and progressive weakness are not particularly important symptoms of heart disease, except in cases of hyperthyroidism and long standing cases of congestive failure. There was a gradual downhill trend until the evening of April 1, about a year after the patient first became ill, when she became suddenly more dyspneic and then went to the hospital. She had marked cyanosis and orthopnea, but no cough at that time; rapid accumulation of chest fluid taking place within forty-eight hours, and fibrillation, persisting in spite of medication.

Now let us discuss the case as a whole. We have some disadvantages in this discussion and some advantages. We can discuss the case from the standpoint of the whole picture, but at the same time we are at a disadvantage in not being able to examine the patient ourselves or getting more data. The outstanding thing here is the story of a woman with auricular fibrillation, but with no evidence, except on this one electrocardiogram, of heart failure, until perhaps the last few hours of her life.

What are the causes of auricular fibrillation? Under what conditions are we most apt to meet it? Of course, it is very common in rheumatic heart disease. But in this case there is no indication of any specific murmur or of rheumatic heart disease, and there is no enlargement of the heart; usually patients developing fibrillation as a result of rheumatic heart disease are the older ones, especially those with failure of compensation. Thus, it seems very unlikely that this woman could have had rheumatic heart disease.

Now then, hyperthyroidism. Both varieties are common causes of fibrillation, either paroxysmal

or persistent. This woman had rapid fibrillation, but apparently between the attacks she did not have an excessive heart rate. She apparently did not have the usual symptoms that go with hyperthyroidism. She hadn't lost weight until those last few months. The basal metabolic rate noted was the only one made, and one, of course, is not particularly reliable, but it was minus thirteen per cent and thus within the lower limits of normal. That isn't all we would need to make the diagnosis of her not having hyperthyroidism, but it certainly isn't in favor of it. And there were just not things that appealed to me as indicating that she had that condition.

We see auricular fibrillation in cases of hypertensive heart disease, but there is no evidence of heart disease here, and the heart isn't even enlarged. It wasn't failing, until late, and hypertension certainly was not stressed anywhere in the history.

Coronary artery disease, or coronary sclerosis, is not a common cause of auricular fibrillation except following frank coronary artery occlusion with myocardial infarction. There is nothing in this story to indicate a specific incident that would lead us to think of a myocardial infarction. It is possible that she had the coronary sclerosis. She was 62 and the electrocardiogram said that she had evidence of frank coronary sclerosis with serious myocardial damage. And it is quite possible that she did have coronary sclerosis of significant or important degree. The question is, however, whether that is the important thing, or the most important thing in the case. We must not be confused and jump to the conclusion that, because she had evidence of coronary sclerosis and because there is a possibility that she had it, that she did have it. But if we think that she did have coronary sclerosis it wouldn't be a bad bet, anyhow. She is 62, you know.

Another cause of fibrillation not commonly thought of is chronic constrictive pericarditis. I have had a number of these patients, and a certain percentage, in fact, a considerable percentage, have auricular fibrillation, usually persistent rather than paroxysmal. Now, did she have this condition? In this disease, you know, there is usually no enlargement of the heart. This patient didn't have enlargement of the heart. There is usually enlargement of the liver, which is not indicated in this case, and that doesn't help us. And there is no indication of a high venous pressure (the venous pressure was not given in the history), and she did not have ascites. I prefer to use the triad: Small, quiet heart; high venous pressure; and enlargement of the liver unexplained in other ways, because I have observed that ascites is very often absent in such cases. She didn't have an enlarged liver, and we don't know whether her heart was quiet, that is, whether it didn't expand much with each beat of the heart. We don't know about her venous pressure. Certainly there isn't very much in the history to give us the evidence of chronic constrictive pericarditis, although it can't absolutely

be ruled out.

And then another cause of auricular fibrillation is bacterial endocarditis, of which there was certainly very little evidence in this case. And it is interesting to comment at this time that patients with auricular fibrillation rarely, if ever, get bacterial endocarditis. But patients that develop bacterial endocarditis may develop auricular fibrillation. Thus, if they have had auricular fibrillation before they became ill, they probably do not have bacterial endocarditis.

Now lastly, tumor of the heart—and this is something that perhaps all of us didn't think about, will cause auricular fibrillation. And how will it cause auricular fibrillation? Metastatic lesions in the auricles cause auricular fibrillation. In the cases I have had, however, it has been a terminal condition, and persistent rather than paroxysmal. In this case the patient had auricular fibrillation for a year intermittently. But in the history, from January to April, the last few months before her death, she had symptoms that should go with a malignant tumor of the body—loss of weight, strength, and appetite. And she had fluid in the right chest that was hard to explain, since she did not have evidence of congestive heart failure.

So, therefore, to summarize, since there is no use in prolonging the agony, by exclusion I think—unless they have been holding out on us here some important information—we can rule out about everything except coronary sclerosis and tumor of the heart. I think we have considered about everything that could have existed. We have evidence here of both coronary sclerosis, if the electrocardiologist isn't misleading us, and a malignant neoplasm. It is rare to have metastases in the heart unless there is a more or less general carcinomatosis. Although this patient may have had coronary sclerosis, it is hard to see that all of her troubles were due to that. Probably she had coronary sclerosis and developed a malignant neoplasm that metastasized to the right auricle of the heart.

* * *

DOCTOR HALL: Doctor Cheney, Doctor Yater, Members of the Association: I have a profound respect for these internists. They are well trained, like Doctor Yater, and I'm sure that he will do no blushing. When he told me that he didn't know what this was, I didn't believe him, and I find that I am right.

This first slide isn't too good, but it is the best we have and we're probably lucky to have it. These are the heart and the lungs, and in the mediastinum one of the tracheobronchial lymph nodes. There is a greyish-white tumor which is bent into the main bronchus of the right lower lobe. The bronchus was considerably narrowed, but the mucous membrane was not involved. The orifice of the right pulmonary veins entering the left auricle and one of these veins were practically occluded. The wall of the auricle is infiltrated with this grey tumor which extends practically

to the mitral valve. The mitral valve is a bit thickened, apparently by an old, healed rheumatic lesion, probably not of much moment. There was rather marked coronary sclerosis in this case, but no infarction of the heart, and the aorta showed rather marked sclerosis as well. There was some pericarditis at the base of the heart over the left auricle, the tumor had penetrated the pericardium and produced a moderate pericarditis of that portion of the heart. The pulmonary artery was free. The heart was only slightly enlarged, and the valve orifices were of normal circumference. There was a large plaque at the ostium of the right coronary artery, which narrowed the ostium somewhat, and there was some thickening of the endocardium of the left ventricle. The wall of the left ventricle measured thirteen millimeters, the right seven millimeters. The liver weighed 1150 grams and showed no marked change and only a moderate degree of passive congestion. The gallbladder contained many brown, faceted gallstones from one millimeter to two centimeters in diameter. The other organs were essentially normal.

In this second slide we have a section through the wall of the left auricle. In the midportion, the pink fibers are the heart fibers, and the dark cells are those of the tumor. This tumor is apparently a lymphosarcoma, of the small-cell variety, and is not a carcinoma of a bronchus. The tumor probably originated in the tracheobronchial lymph node.

This third slide shows a section of the interauricular septum showing the same thing. There are muscle fibers scattered throughout this area of very heavy infiltration with small dark cells.

This last slide is the high-power section from the tracheobronchial lymph node; it shows a very heavy stroma of fibrous tissue and the small dark cells that look very much like lymphocytes.

To summarize, then, although there was moderate congestive heart failure, the most important cardiac lesion was infiltration of the left auricle and the septum of the auricles by a lymphosarcoma, apparently a rather slowly growing tumor. The primary source was apparently in the tracheobronchial lymph nodes. In addition, there was generalized arteriosclerosis and rather severe local arteriosclerosis of the coronary arteries, a small embolus in the spleen, more or less perisplenitis, and gallstones.

Georgetown University Hospital.

From an Article on "Medical Inspection of Prisoners at San Quentin. With Report of Case of Tinea Versicolor," by L. L. Stanley, M.D., San Quentin.—Each prisoner upon entering San Quentin prison is subjected to a thorough physical examination. As soon as he enters, he is taken to the turnkey's office, properly registered, and instructed as to his privileges and requirements. After a bath, a shave, and a cropping of the hair he is taken to the Bertillon room, where his physical measurements are tabulated, as well as any scars, deformities, birthmarks and the imprints of the palmar surfaces of his thumbs and fingers. His face is photographed both from in front and laterally for records of identification. . . .

PRIMARY PAPILLARY CARCINOMA OF THE URETER*

WITH REPORT OF A CASE

A. J. SCHOLL, M.D.

AND

V. J. GALLAGHER, M.D.
Los Angeles

URETERAL tumors, until the last decade, were considered to occur only rarely. Reports appearing since the more general acceptance and use of newer urographic procedures indicate that not only are we now discovering tumors that would previously have been overlooked, but we are finding them at an earlier, more curable stage.

Ureteral tumors, similar to tumors of the renal pelvis, are most commonly papillary in type, though cases of squamous cell and, more rarely, benign tumors have been reported. Usually occurring in the lower third of the ureter, these papillary growths are of a high degree of malignancy. They grow rapidly and have a marked tendency to recur after removal.

Due to delay in treatment, or as the result of an incomplete operation, the immediate and late mortality have been high in the reported cases. Early diagnosis, and a more thorough removal of the tumor and regional structure, should give us the the same satisfactory postoperative results which are now obtained in the treatment of papillary tumors of the bladder, a group not dissimilar in type and degree of malignancy.

The following case report is of interest mainly because it illustrates the accuracy of diagnosis obtainable by present cystoscopic and urographic procedures. It also affords an opportunity to discuss nephro-ureterectomy, a procedure especially suitable not only for malignant conditions of the ureter but also for other conditions causing ureteral obstruction and infection.

REPORT OF CASE

Ureteral tumor, causing ureteral obstruction and renal damage. Complete nephroureterectomy, fulguration of intramural portion of the ureter, followed by postoperative x-ray therapy.

CASE 1.—C. B., a male, aged 35, was seen shortly after a two-day attack of hematuria. He had similar attacks three months and six months earlier. Six months ago he had a short period of low back pain which made it difficult for him to stand erect. More recently he has had pain in his right loin which occasionally radiates to the scrotum.

The urine contained red blood cells, leukocytes, and a trace of albumin. An examination of the blood revealed nothing abnormal. The Wassermann examination was negative. A nonprotein nitrogen determination was 30, and the two-hour phenolsulphonephthalein return was 90 per cent.

No masses or tenderness were found on physical examination. The prostate was normal on palpation, and the expressed prostatic secretion contained only a few cells. There was a moderate-sized scar of an appendectomy incision in the lower right quadrant of the abdomen.

The x-ray of the kidneys, ureters, and bladder revealed nothing unusual.

Cystoscopy showed a normal urethra and bladder, except for moderate inflammation around the right ureteral orifice. The urine from both ureters was clear. Intravenously-injected indigo-carmin returned from both ureters in four minutes, the left normal in amount, the right markedly diminished. A left ureteral catheter was passed up the left ureter without difficulty. The catheter on the right side met an obstruction about 8 cm. above the orifice.

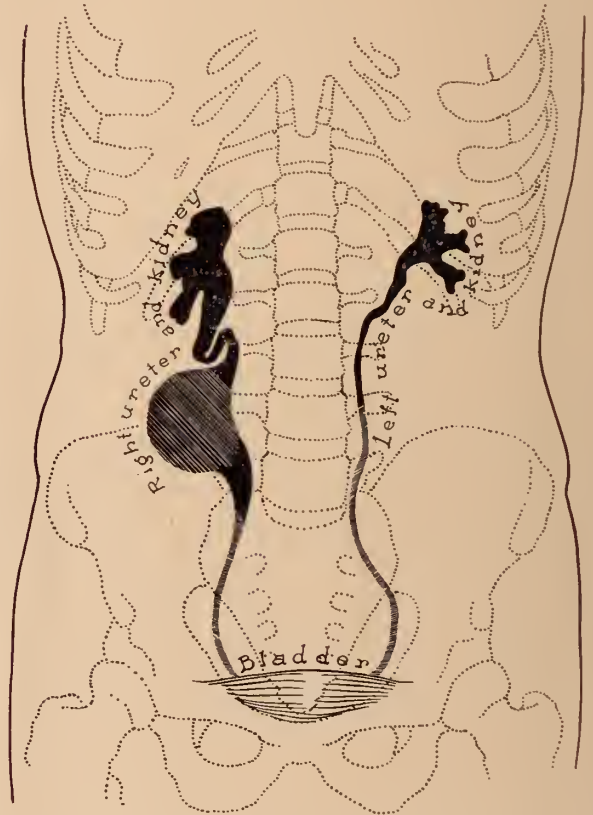


Fig. 1.—Dilatation and filling defect in middle-third of ureter.

The pyelograms showed a normal left pelvis and ureter. On the right side the catheter only reached the level of the crest of the ilium where it turned lateralwards. At the point of turning, the injected opaque medium disclosed a marked dilatation of the ureter with a large filling defect above it. (Fig. 1.) Repeated injection failed to force the opaque fluid above this area. Films taken five, fifteen, and twenty-five minutes after intravenous injection of diodrast showed the dye in good concentration in the pelves and calices of both kidneys. No abnormality was noted on the left side. There was marked enlargement of the calices of the right kidney, and slight enlargement of the kidney pelvis and upper third of the ureter. The upper portion of the right ureter was tortuous. About the middle of the ureter, there was considerable dilatation with a large filling defect measuring over 5 cm. in diameter. The left ureter was normal in course and diameter. Films taken with the patient in an upright position showed that the region of the filling defect in the right ureter was freely movable. Excursion of both ureters was within normal limits. A film taken one hour after injection of diodrast showed that there was fair drainage of the right kidney. The bladder was moderately

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distended and normal in outline.

A diagnosis of ureteral tumor was made, and a right nephroureterectomy planned.

Operation. Spinal anesthesia. The patient was placed on his left side and the kidney explored through a right postero-lateral incision. The lower angle of the incision was placed as closely as possible to the crest of the ilium so as to give the best possible access to the lower portions of the ureter. The kidney, which was a little larger than normal but of good consistency, was readily delivered into the wound. The ureter was freed from adhesions, and on tracing it downward, a fusiform swelling about 2 x 8 cm. in size was found in the middle third. This mass was soft, freely movable, and not adherent. The renal pedicle was then clamped, cut, and tied, and the kidney still attached to the ureter was brought out through the anterior angle of the incision. The ureter was then freed down as far as possible, several Penrose drains inserted, and the kidney incision closed. Several sutures were inserted and left untied in the anterior angle of the wound, to be tied after removal of the ureter. The patient was then turned on his back, and a second incision was made paralleling the right border of the rectus muscle. The rectus muscle was pulled toward the midline, and the peritoneum was separated from the lateral wall and retracted medianwards. Adhesions from the old appendectomy incision prevented any extensive exposure, leaving only a small area below the scar which could be explored without tearing the peritoneum. Traction on the upper ureter aided in identifying the lower segment, which was then freed of its adhesions down to the bladder wall and upward to that portion reached from the postero-lateral incision. The bladder wall was grasped with forceps, the ureter cut, fulgurated, and the upper end tied. A fulgurating electrode was then inserted through the intramural portion of the ureter into the bladder, and the intervening segment of mucosa and muscularis thoroughly charred. The bladder was then closed with plain catgut sutures. The wound was drained and closed in the usual manner. (Fig. 2.)

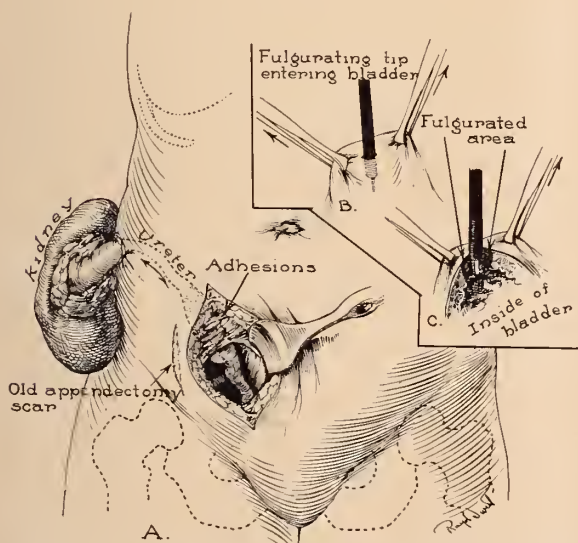


Fig. 2.—A. Kidney removed through flank incision before cutting lower ureter. Ureter then withdrawn through incision in flank.

B. Intramural segment of ureter charred with fulgurating electrode.

The patient had no trouble following operation. Several weeks later a course of therapeutic x-ray was given over the lower right ureteral area. Eight months later the patient had gained fifteen pounds; there were no signs

or symptoms suggestive of recurrence; and cystoscopy revealed nothing abnormal.

COMMENT

The above case is of interest in that the age of the patient (35) is much lower than the average (58 years) of patients with ureteral tumors.

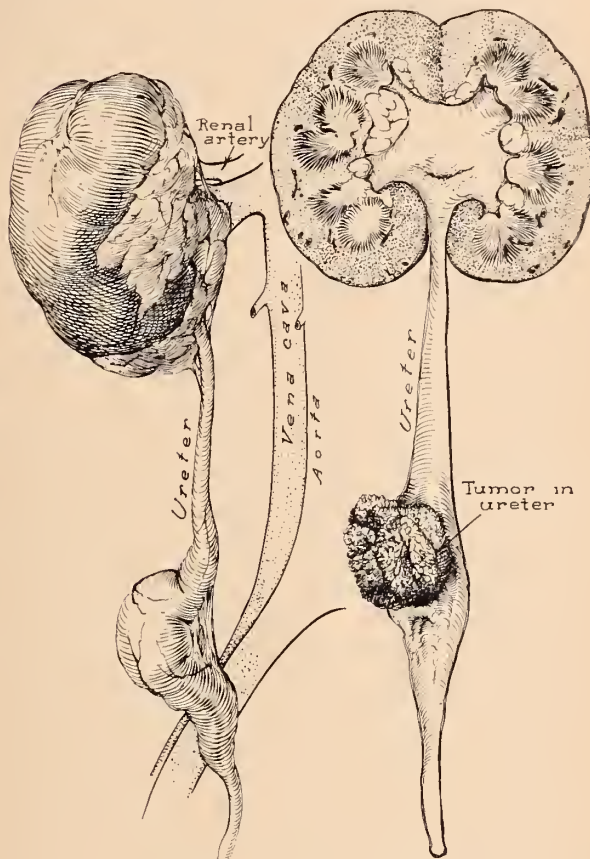


Fig. 3.—Kidney and ureter showing papillomatous mass in midsection of ureter.

The growth, which was of a low degree of malignancy, was apparently confined to the ureter; there were no periureteral adhesions and only little invasion of the ureteral wall. There was a long segment of normal ureter below the tumor, and the bladder showed no evidence of transplants (Fig. 3). Complete removal of the kidney and ureter with its overlying tissues, together with thorough fulguration of the intramural segment of the bladder, should make the prognosis not unfavorable.

DIAGNOSIS

Before the introduction of more accurate methods of urologic diagnosis, undoubtedly many cases of ureteral tumor were overlooked.

The most common symptom is hematuria; mild and intermittent in the early stages, it later becomes more profuse and at times continuous. The blood is usually mixed with the urine, and may be spontaneous or follow exertion. The

urine, even between attacks of hematuria, contains some red blood cells and leukocytes. Occasionally clots are formed, which may be long and thin, representing a cast of the ureter. Intermittent pain in the renal area is at times associated with the passage of clots.

In some cases ureteral obstruction does not develop, or else it is so slow and gradual that it does not cause pain. Usually there is some pain resulting from obstruction of the ureter by the tumor. Occasionally obstruction may cause a large or hydronephrotic kidney which can be seen or felt on examination.

During the last decade many cases of ureteral tumor have been diagnosed earlier, at a more favorable stage for operation. This, together with the proper treatment, should give much better postoperative results than were formerly obtained. In only 14 of 49 cases collected by Roussetot and Lamon¹ in 1930 was an accurate preoperative diagnosis made. More exact cystoscopic and urographic procedures have been of great value in diagnosing these tumors.

The bladder may be normal on cystoscopic examination, or there may be a bulging of the corresponding ureteral orifice or an area of redness about the opening. A small papillomatous mass is sometimes seen projecting from the ureteral orifice, or it may come into view, or the ureteral area may bulge down only with ureteral peristalsis. Tumor tissue projecting from the ureter, surrounding the orifice or producing multiple transplants to the bladder wall, does not occur as readily or as freely with primary ureteral tumor as it does with the papillomatous ureteral tumors which are secondary to renal pelvic tumors.

Blood may be seen coming from the orifice; it is usually merely a trickle, easily washed away with the irrigating fluid. Ureteral obstruction or distention of the ureteral wall inhibits ureteral peristalsis and prevents the usual spurts of urine, whether blood-tinged or clear. On attempting to pass a ureteral catheter, an impassable obstruction may be encountered, usually in the lower third of the ureter. This is not necessarily due to complete ureteral obstruction as much as to difficulty in passing around or through the folds of tumor tissue. Catheter manipulations may cause bleeding, which passes through the catheter or is seen exuding through the orifice about the catheter. It has also been found that, while blood-stained urine is collected when the catheter is below the tumor, urine free of blood may be obtained when the catheter is forced beyond the tumor.

Urography, both retrograde and excretory, is of great value and has established the diagnosis in a definite number of cases that might have been overlooked entirely or discovered only after a preliminary kidney exploration. If the ureteral catheter can be passed by the obstruction, a nephroureterogram may show a filling defect indicating the location and size of the tumor. Rusche and Bacon² were able to outline the tumor in one of their cases by gradually withdrawing the ure-

teral catheter and taking repeated urograms. If the ureteral obstruction is impassable, an injection of the lower segment of the ureter may outline the lower border of the ureter and show the extent of the ureteral dilatation, and also some of the contrast fluid may extravasate through the tumor. Excretory urography may be unsatisfactory in cases of long-standing ureteral obstruction and consequent loss of renal function. In cases such as the one reported above, where the obstruction is incomplete or of short duration, an excellent delineation of not only the upper but the lower ureter as well may be obtained.

The ureter below the site of the tumor is usually normal, and that portion above the tumor dilated, especially in cases of moderate obstruction.

TREATMENT

A number of different surgical procedures have been suggested in the treatment of tumors of the ureter—cauterization, fulguration, partial resection of the ureter, reimplantation of the ureter into the bladder, and other measures. Papillary tumors of the ureter, some of which may appear to be histologically benign, are nearly all clinically malignant. Similar to papillary tumors of the renal pelvis and bladder, recurrence, extension and transplantation of the growth are more frequently found than not. Consequently conservative measures are insufficient, and an effort should be made to remove the entire ureter and to destroy as much of the bladder wall as necessary. The best results have been obtained with complete nephroureterectomy, combined with some method of disposal of the ureteral area in the bladder such as advised by Colston³ and Stang and Hertzog.⁴ Cook and Counsellor⁵ advise resection of the ureteral segment, including all the layers of the bladder wall and the overlying tissue, in order to eliminate the possibility of lymphatic extension from the tumor to the bladder wall.

Nephroureterectomy is an operation which, until the last decade, has been performed only rarely for tumors involving the ureter. Kelly,⁶ in 1896, was one of the first to advocate this procedure. He removed the kidney and ureter through a single long incision. Later Lilienthal⁷ called attention to a simpler, less-mutilating approach in which the kidney was removed through the usual posterior incision, the ureter being left projecting from the incision. The lower ureter was freed, ligated, and cut through a low inguinal incision, being then pulled through the posterior incision. Beer,⁸ in 1921, reported a case of ureteral tumor in which he removed the entire kidney and ureter intact through the posterior incision. The ureter was cut off at the bladder through a low rectus incision. All precautions were taken not to contaminate the large retroperitoneal wound.

Nephroureterectomy, while also of value in other conditions, is definitely indicated in cases of tumor of the ureter, whether the growth is

primarily a ureteral one or whether it is secondary to a tumor of the renal pelvis. Hunt,⁹ in a review of cases of tumor of the renal pelvis, stated that 9 of 15 cases of papillary epithelioma of the renal pelvis had recurrence or extension of the growth to the ureter following simple nephrectomy.

There is very little difference in the difficulty of removing the kidney and ureter as a single unit, whether the lower ureter is freed from its attachments before the nephrectomy or after. In cases where nephroureterectomy is indicated for conditions other than tumor, the kidney should be explored first, as not infrequently it is possible to reach a sufficient segment of the ureter from the posterior wound.

In Beer's⁸ original description of his aseptic ureteronephrectomy for ureteral tumor, the kidney was delivered before exploring the lower ureter. In cases where the diagnosis was definitely established, Judd¹⁰ usually freed the kidney first; he stated that traction on the upper ureter aided in locating the lower ureteral segment. In cases where an extension of the tumor to the bladder wall required a partial resection of the bladder, Hunt⁹ first removed a segment of the bladder with the attached ureter before doing a nephrectomy, at which time the entire mass, kidney, ureter, and bladder segment were all removed in one piece. Gutierrez¹¹ advocates the introduction of a ureteral catheter before surgical exploration to aid in locating the ureter.

In the case reported above, nephrectomy was definitely necessary; the ureterogram indicated that the ureter was movable and unattached, and cystoscopy had shown that no time-consuming resection of the bladder would need to be done. The presence of an old, muscle-splitting, appendectomy incision, and its attendant peritoneal adhesions, would limit any extensive upward exposure of the ureter through the lower incision. Therefore, nephrectomy was done first through a lumbar incision, and the ureter separated from its attachments from above downward, and an effort made to free the ureter as low down as possible. This extensive dissection from above downward simplified the second step in the operation, for the exposure obtained through the right rectus incision, as anticipated, was definitely limited by the peritoneal adhesions around the appendectomy scar.

PROGNOSIS AND MORTALITY

The numerous recent reports of cases of ureteral tumor may stimulate our interest and aid us in the recognition of these cases while they are still in a curable stage. Stang and Hertzog⁴ report that more than one-half of the total number of cases in the literature have been recorded in the last eight years. Most published reports indicate rapid recurrence of the tumor, a high operative mortality, and in most cases a quickly fatal outcome.

There are several factors besides late recognition of the tumor which contribute to the high

mortality. The tumors usually occur in elderly people; the average age in several series of reported cases was 58 years. The location of the growth causes urinary obstruction and renal damage, and surgical removal necessitates an extensive incision, exposing wide areas to tumor invasion and infection.

A chronologic review of the literature shows an increasing number of cases being found. Rousselot and Lamon,¹ in 1930, found that 30 of a group of 49 collected cases died under treatment or shortly afterwards.

Scott,¹² in 1934, discarded some of Rousselot and Lamon's¹ cases, added 2 of his own, and discussed the results of a group of 61 cases. Seventeen patients were treated palliatively; 45 were operated upon with a mortality of 27 per cent. In 18 of the remaining cases, death occurred shortly afterwards, in 13 from the results of the tumor, in 5 from unknown causes. Of those patients on whom late postoperative data were obtainable, 50 per cent died within twelve months. Only 2 of the entire group were known to be living and well five years after operation.

Rusche and Bacon² reviewed the literature in the period since the publication of Scott's paper¹² until 1936; they found 26 cases and added 1 of their own. In 14 cases nephroureterectomy was done for ureteral tumor; in 1 of these no postoperative data was obtainable. In 8 of the remaining 13 cases, death occurred directly or shortly after operation. Only 1 of 6 patients on whom two separate operations were done was alive. One patient died following a primary kidney operation. Four had no surgery for various reasons; all died. Two cases were found at autopsy. In all, only 6 of the 27 collected cases were alive.

In 1939, Foord and Ferrier¹³ were able to collect 139 cases, including those of Scott¹² and Rusche and Bacon.² In 100 surgical cases, 34 per cent died following operation or shortly afterwards. The immediate operative mortality in 44 one-stage nephroureterectomies was 40 per cent.

Many ureteral tumors are of a high degree of malignancy which has a definite bearing on the prognosis. Cook and Counseller,⁵ in a discussion of the degree of malignancy in these cases, noted that 7 of 10 patients with ureteral tumors and a malignancy grading of I or II (Broder's classification), were alive for from 1 to 9 years after operation. In contrast to this, 5 of 7 patients with a malignancy grade of III or IV were dead; 1 was alive 8 years after operation and 1 was not traced.

Many reported cases were seen late in the course of the disease. Simple nephrectomy was performed in a number of cases, persistent pain and hematuria finally directing attention to the ureter. In view of our present knowledge of these tumors, it is possible that many cases did not receive early or adequate treatment. Better results should be obtained in future cases. More general use of intravenous urography may permit recognition of the growth in a larger number of cases

while the tumor is still in an operable stage, and there is also a better understanding of the need for thorough removal of all potential tumor-bearing tissue.

SUMMARY

The reported results of cases of tumor of the ureter all indicate a high mortality following surgical treatment. Delayed, inadequate treatment, urinary obstruction, and infection, together with a high degree of malignancy, all contribute to increase the operative risk.

A case is reported of a male, aged 35, with a papillary tumor of the ureter. The kidney and ureter were removed and the bladder segment containing the mural portion of the ureter thoroughly fulgurated. This case is of interest on account of the early age of the patient, the positive clarity of the intravenous pyelograms, and the ease of surgical removal of the potential tumor-bearing tissues.

1930 Wilshire Boulevard.

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"We know that sometimes a price must be paid for civilization and peace; and when madness and passion and the desertion of all the standards of decency and good faith bring a great agony to the world, it is sometimes the manifest duty and the high privilege of a free people, by the power of sacrifice and courage, to transmute that agony into a new salvation. In this war, we have no illusions about the strength of the enemy or the length of the war. We know that wars can not be won by abstract nouns and that tyrants can not be hanged by a string of adjectives. We have freely made our choice and we propose to abide by the issue with all free men until the end."

THYROID DISEASE*

EXPERIENCES AND CONCLUSIONS OF A THYROID COMMITTEE†

H. H. SEARLS, M. D.

San Francisco

IN the University of California Hospital, during the past three decades, 4722 operations for goiter have been performed by various members of the surgical visiting and resident staffs.

The mortality rate (1.4 per cent for the whole series) has varied from year to year, with a fortunate downward tendency best illustrated graphically. (Fig. 1.) In the past 17 years, the main bulk of our series (4062 partial thyroidectomies) has been developed. During this time 40 deaths occurred (0.98 per cent). Since the organization of the thyroid committee 11 years ago, there have been 21 deaths in 2531 partial thyroidectomies (0.83 per cent). The operations were performed by approximately 20 surgeons, 15 of whom were resident surgeons at the time of their contributions to the series. Follow-up studies were insufficient and casual at first, but during the past 5 years, these studies have been maintained at 100 per cent. To date none of the 410 service patients operated on for goiter during the past 5 years has had a recurrence of the disease. Of these patients, 11.6 per cent developed hypothyroidism, and an additional 7.5 per cent had myxedema. As encountered in the follow-up, patients with these sequelae have been relieved by the oral administration of thyroid substance. With these exceptions, universally good results have been obtained during this period.

From 1912 to 1920 the pioneering study of the diagnosis and treatment of goiter by Drs. H. C. Moffitt and W. I. Terry established a firm basis for the whole series. In the following decade the constantly-increasing size of the series stimulated the interest of younger members of the staff until, in 1930, a committee‡ was formed, to meet each week for the study of new patients with thyroid disease, and the review of old cases. For the past 11 years, this committee, composed of internists, roentgenologists, pathologists and surgeons, has observed these patients and discussed their diagnosis and treatment. At first the various members held numerous, diametrically opposed, rather fixed ideas on many of the points under discussion. Gradually, by convincing argument and demonstration, most of these divergent opinions have become harmonized. Now, agreement as to diagnosis is universally attained, and at least a recognition of the value of the various methods

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† From the Department of Surgery, University of California Medical School.

‡ Thyroid Committee, University of California Medical School: Theodore L. Althausen, Evelyn Anderson, Edwin I. Bartlett, H. Glenn Bell, Charles L. Connor, Leon Goldman, Carl L. Hoag, William J. Kerr, Hans Lissner, William A. Reilly, James F. Rhinehart, J. Maurice Robinson, Henry H. Searls, H. Clare Shephardson, Mayo H. Soley, Robert S. Stone, Wallace I. Terry, Robertson Ward.

of treatment is admitted by all.

It is my privilege to present to you some of the ideas, impressions and conclusions which have developed in the minds of the committee as this mass of material has passed in review. Out of friendly discussion and, occasionally, heated debate, have come conceptions which have improved our understanding of the many ramifications of the problem.

tients a fair estimate of the regions of Northern California in which the inhabitants are more likely to develop goiter has been charted.

Out of studies in the differential diagnosis between the hyperthyroid state and other conditions closely simulating it, have come clearer pictures of the menopausal syndrome and of anxiety states exhibiting hyperventilation. In the patient at menopause, who has an enlarged thyroid, the

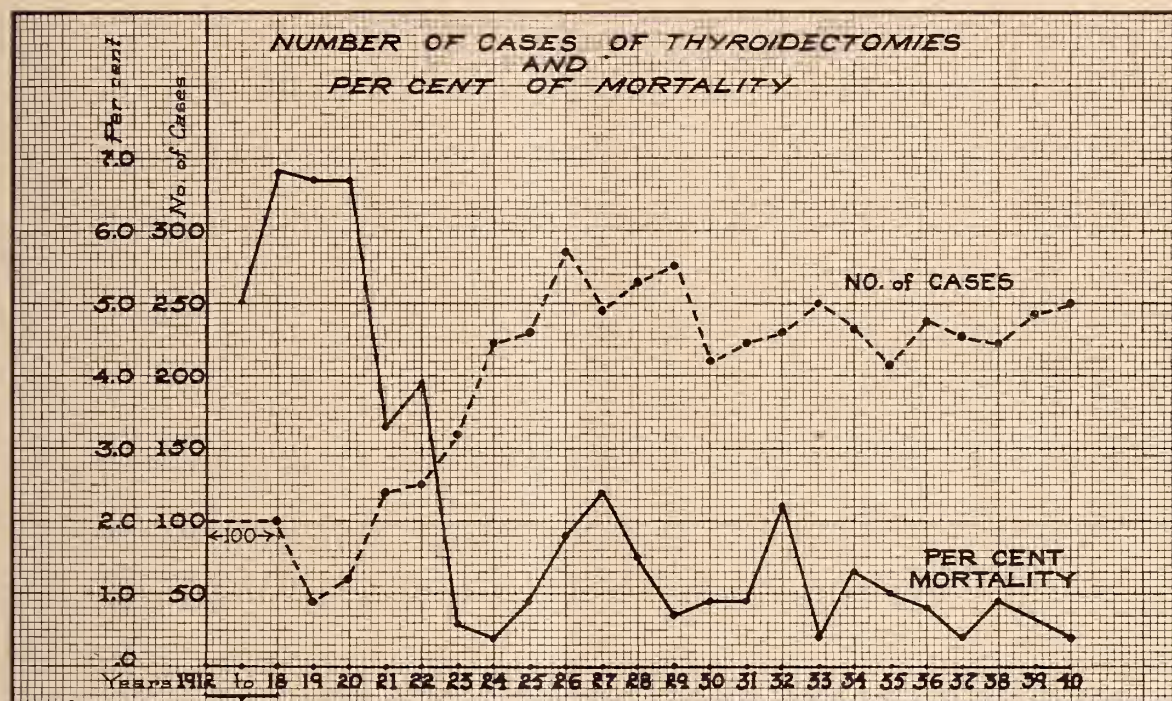


Chart 1.—Number of cases of thyroidectomies and per cent of mortality.

In the earlier years of our meetings, perhaps the greatest point of disagreement was centered about the clinical picture of adenoma with hyperthyroidism, and its possible relationship to exophthalmic goiter. The younger internists, siding with the pathologists, insisted that, usually, the two conditions were but different manifestations of the same disease. The older internists, together with the surgeons, considered them as separate clinical entities. Through the forces of argument, demonstration and an increasingly supportive literature, the surgeons have come to recognize the probable truth of the contention of the younger internists. Basic differences in the *treatment* of the two conditions, however, are recognized by most of us. Thus, as in many other instances, discussion has developed a convergence of opposing beliefs.

The patients and their records, in such a large series, have presented to the members of the committee many leads for special investigation. The results of some of these studies follow.

SPECIAL INVESTIGATIONS

From the history of residence of over 400 pa-

question often arises concerning the presence or absence of hyperthyroidism. In the differentiation, the usual features of hyperthyroidism, such as tachycardia, loss of weight, increased appetite, exophthalmos, increased vascularity of the gland and high basal metabolic rate, are of value in confirming the diagnosis of toxic goiter. Other symptoms and signs, such as nervousness, tremor, emotionalism, irritability, intolerance to heat and hyperidrosis may be of menopausal origin and therefore misleading. Heat intolerance and hyperidrosis, however, are not constant in a given patient at the menopause, but may alternate with a sense of cold, whereas they *are* constant in the patient with hyperthyroidism. A therapeutic dose of an estrogenic substance, such as estrodial dipropionate ($2\frac{1}{2}$ mg intramuscularly), should prove to be differential, as it will relieve menopausal symptoms in a few days, but will have no effect on the patient with true hyperthyroidism.

The faster way of living, economic upheaval, war news and other disturbing elements have all contributed to an increase in the number of those persons classified by the psychiatrist as exhibiting an anxiety state. One of the manifestations of

an anxiety neurosis is the hyperventilation syndrome. The nervousness, emotionalism, tremor and tachycardia associated with this peculiar habit of overbreathing may simulate hyperthyroidism. Now, only in very rare instances can nontoxic, diffuse goiter be considered surgical. Yet frequently such a goiter has been removed in error because a coincident hyperventilation syndrome was mistaken for hyperthyroidism. The failure to gain relief thereafter is disappointing to surgeon, patient and relatives. In borderline cases the hyperventilation syndrome should be ruled out by investigation of the psychic state, by observation of the breathing habits (often best shown on the graph at the time of a test of basal metabolism), by attempted reproduction of the symptoms through forced overbreathing, and by therapeutic test with ammonium chloride or carbon dioxide.

THYROIDITIS

The committee has followed, with great interest, the patients who have come to us with the various types of inflammation of the thyroid gland. Acute thyroiditis has been encountered only rarely. Usually it was nonsuppurative and responded to medical measures. In several instances suppuration supervened, requiring incision and drainage, followed in each case by a return to normal health, without impairment of thyroid function. A rare but interesting *wandering* type of acute thyroiditis has been seen in the series. In association with fever and malaise, a tender indurated area develops in one lobe of the thyroid and, healing as it goes, slowly proceeds to other parts of the gland. A sense of pressure on the trachea is a miserable symptom. It is our belief that surgical treatment is not indicated and that the condition will resolve completely with rest, local heat or cold, and measures to combat the toxemia. Progress is slow and six weeks may pass before relief is obtained. Consequent hypofunction has not been observed.

Chronic thyroiditis has occurred more frequently. In this disease a moderate fibrosis and lymphocytic infiltration are common findings in the microscopic picture. Rarely, the inflammatory process may progress to a complete or nearly complete replacement of the glandular tissue by an overwhelming fibrosis. First described by Riedel, the picture is that of an iron-hard goiter causing extreme constrictive pressure on the trachea. Hypothyroidism develops after either resection of the isthmus, or the more rational procedure of subtotal thyroidectomy. We have met this condition in only five instances in our series. Hashimoto's struma, a type of chronic thyroiditis in which lymphoid elements replace the glandular structure, has been seen in 10 instances. Pressure on the trachea drives the patient to seek relief. Differentiation from the Riedel type is difficult except microscopically. In most of these, subtotal thyroidectomy has been our treatment. Marked hypofunction, approaching myxedema, has fol-

lowed whether or not any surgical treatment was instituted.

MALIGNANT GOITER

The committee has had an excellent opportunity to study malignant goiter. One hundred and twenty-one cases of malignancy have been observed. From the study of the case records of this group a strong conviction has developed that, in a very high proportion of cases, cancer of the thyroid is a malignant degeneration of a preëxisting benign nodular goiter. In the whole series the ratio of thyroid malignancy to nodular goiter was as 1 to 34 in women, and 1 to 17 in men. When questioned, the patient with malignant goiter often relates having had an asymmetric goiter for years, with recent sudden enlargement. Such a story is so commonly encountered that the committee is convinced that nodular goiter should be considered as a precancerous lesion. This threat of a possible malignant change in a nodular goiter is, in our eyes, the prime indication for its surgical removal; any change in the consistency or in the rate of growth of a nodular goiter renders its removal imperative. The preoperative determination of malignancy in a nodular goiter can be established only after it has progressed beyond surgical cure. If gross or microscopic examination of the specimen shows cancer, radical surgery should be followed by a full course of roentgen therapy. The prognosis in malignant goiter varies with the microscopic pattern. Papillary adenocarcinomata may be held dormant for years, or even cured by radical surgery and the judicious use of x-ray treatment. On the contrary, some of the patients with malignant adenoma of fetal pattern, and those with the so-called malignant adenoma of Langhans have obtained little or no benefit from surgery or x-ray, and have suffered early recurrence which quickly terminated in death. Evidence of round cell or polymorphonuclear infiltration among the cancer cells is of grave prognostic significance. Usually, the younger patients have a better prognosis.

As in other clinics an increasing interest in "lateral aberrant" thyroid tissue has developed here. Its precancerous character renders its recognition most important. Usually of a papillary cystadenomatous type, it is found along the jugular veins and in the upper mediastinum. If aberrant thyroid tissue is encountered, all such regions should be explored and, if any further nodules are discovered, they should be removed in their entirety.

LABORATORY PROCEDURES

Among laboratory procedures, the test for basal metabolic rate remains the best index of thyroid function. Various factors besides the degree of thyroid activity influence the basal metabolic rate, and may render it misleading. The patient may have an abnormally low level of basal metabolism in good health. In such a patient, although she becomes evidently toxic, the development of hyperthyroidism may fail to bring the rate up-

ward as far as zero. Such masked hyperthyroidism has been encountered often in this series, especially in the patient with toxic nodular goiter.

Determinations of blood cholesterol are of value in checking against the basal metabolic rate. In the presence of a normally functioning liver, the blood cholesterol is low in hyperthyroidism and high in hypothyroid states and in myxedema. In general, blood cholesterol readings are in inverse ratio to the basal metabolic rate.

In hyperthyroidism galactose tolerance is about three times normal, but is abnormally low in hypothyroid states.

TREATMENT

The committee is in fair harmony concerning the *treatment* of diseases of the thyroid gland. It agrees that iodine should be used as a prophylactic public health measure, especially in regions known to favor the development of goiter.

Simple or adolescent goiter should be treated under close observation by the oral administration of thyroid substance in a dosage sufficient to produce slight hyperthyroidism. From three to four grains daily usually will reduce the size of the gland. Except as a prophylactic, iodine is of no therapeutic value.

Nodular goiter is considered surgical whether or not toxicity has developed. Removal of all the nodular part should be accomplished; if possible, a moderate amount of grossly normal tissue should be preserved. We have considered its treatment by x-ray as irrational.

Toxic diffuse goiter (exophthalmic goiter) has been treated by subtotal resection in the large majority of instances, and such therapy remains our choice of procedure. A selected series (70 cases) has been successfully relieved by adequate roentgen therapy. For this type of treatment we have chosen only moderately toxic patients, without complications, who were not breadwinners and therefore were able to spend more time to obtain a cure. Hypersensitivity of the tracheal and esophageal mucous membranes to the roentgen ray is considered a contraindication to its use, and for such patients surgical treatment has been substituted. Early *recurrences* have responded beautifully to relatively small roentgen dosage. In such cases the increased hazard to parathyroids and recurrent nerves from disturbed anatomy, as a result of previous operation, should influence the consultant against further surgery. At times, however, larger recurrences have failed to respond to x-ray and have required reoperation.

The committee encountered an interesting group of 62 children with toxic diffuse goiter. Fifteen were treated by bed rest with or without iodine therapy; in 12 of these the disease was arrested. Five children received x-ray therapy in combination with other medical care, and 4 of them remained well thereafter. Subtotal thyroidectomy was performed for 33, and in 30 the disease was arrested by this means. Two suffered recurrence, and in the third, recurrence developed again after a second operation. From

the experiences of the committee with this group it is felt that subtotal thyroidectomy, or carefully controlled x-ray therapy, is the therapeutic measure of choice in children. Follow-up study of these children showed an absence of postoperative hypothyroidism and an increased tendency for the recurrence of the disease. The committee, therefore, recommends a more radical surgical removal in young patients than in adults.

A very small carefully-selected group of patients with diffuse goiter and low grade hyperthyroidism have had the disease arrested by small doses of iodine (from 3 to 5 drops once daily) continued over long periods of time.

As a major function of this paper, the committee wishes unanimously to protest against the indiscriminate use of iodine in the treatment of toxic goiter. It is our belief that a long period of iodine therapy in toxic diffuse goiter develops an "iodine-fast" gland—a state which either increases the hazard of surgery very greatly or interferes with a proper response to the roentgen ray. Iodine should not be administered if roentgen therapy is to be used. If operation is decided upon, iodine should be prescribed (10 drops three times a day, after meals) in conjunction with sedation and rest in bed for a period of from 10 days to 3 weeks before operation, or until the pulse rate remains below 90 beats per minute. In toxic nodular goiter, rest in bed and iodine often are unnecessary before operation. Neglected cases of either type of toxic goiter may demand careful study of cardiac, renal and hepatic capacity, and may require weeks and even months of special treatment before operation can be performed with safety.

Patients assigned for roentgen therapy receive a treatment (150 r in air) of the tissues on each side of the neck for 6 successive days, a total of 900 r to each lobe. In addition, on alternate days the thymic area receives 150 r, or a total of 450 r. This course is repeated 6 weeks later, and usually a third course is given after another interval of 6 weeks. More technical details of the treatment may be obtained from our Department of Roentgenology.

Through the years, a constant effort has been made to improve our surgical treatment. Several basic principles have been established. Since Plummer popularized the administration of iodine before operation, we have abandoned the multiple-stage plan of surgical treatment as costly, cumbersome and unnecessary. From the technical standpoint we believe in an absolutely complete hemostasis, permitting closure without drainage. Ligatures and sutures are universally of silk. Only careful anatomical dissection under direct vision in a bloodless field can safeguard the parathyroids and recurrent laryngeal nerves, injury to which carries the tragic threat of possible postoperative semi-invalidism. Radical removal increases the sequel of distressing hypothyroidism and the risk of injury to these important structures. After experiences with residues of varying sizes, we are inclined toward a moderate resection

when dealing with the toxic diffuse gland, seeking by complete follow-up to recognize recurrences early, and to arrest them with the roentgen ray. After operation for toxic diffuse goiter it is our practice to prescribe 5 drops of iodine once daily for 1 month, together with rest and moderate sedation. The importance of frequent follow-up visits for several years cannot be overemphasized.

CONCLUSIONS

In conclusion, the committee would like to reaffirm:

1. That the nodular goiter presents the dangerous threat of malignant degeneration and therefore demands removal.

2. That toxic diffuse goiter may be treated by partial ablation either surgically or (in selected cases) by x-ray.

3. That in toxic goiter the administration of iodine should be reserved for use in the immediate period before surgery.

4. That resection should be more radical in children than in adults.

5. That, in experienced hands, the mortality rate in thyroid surgery approaches zero and complications have become exceedingly rare.

U. C. Medical Center.

HEART UNDER CYCLOPROPANE*

CLINTON H. THIENES, M.D.

AND

PAUL O. GREELEY, M.D.

Los Angeles

ALL general anesthetics alter the rhythm of the heart, and produce changes demonstrable by electrocardiography. The most startling cardiac changes occur during the administration of chloroform¹ and of cyclopropane.² In order to evaluate the importance of the cardiac arrhythmias occurring during anesthesia, several attempts have been made to study the physiological mechanisms involved.

EARLIER STUDIES

Levy drew attention to the possible rôle of epinephrine and the visceral nervous system in the production of ventricular tachycardia and fibrillation during chloroform anesthesia. He observed that injections of epinephrine produced their greatest cardiac effects in cats under light chloroform anesthesia, and that during very deep chloroform anesthesia epinephrine failed to produce ventricular fibrillation. Stimulation of the accelerator nerves, or reflex activation of the sympathetic nerves by electrical stimulation of the sciatic nerve, had effects similar to injections of epinephrine. Until the work of Beattie, Brow

and Long³ it was assumed that the arrhythmias due to chloroform and epinephrine involved only a peripheral mechanism, and there was no apparent explanation for the paradox of greater arrhythmia during light chloroform anesthesia. Beattie, et al, found that transection of the brain below the hypothalamic nuclei prevented chloroform arrhythmias, and later, Dikshit⁴ and Crouch and Elliott⁵ clearly established the importance of hypothalamic centers in the production of cardiac and other circulatory irregularities.

EXPERIMENTS WITH ANIMALS

Epinephrine and a number of other sympathomimetic drugs injected into dogs under cyclopropane anesthesia cause various types of cardiac arrhythmia, including ventricular extrasystoles, ventricular tachycardia and ventricular fibrillation.^{6,7} These effects could not be produced following section of the cardiac sympathetic nerves, nor following paralysis of the sympathetics by ergotamine. These experiments established the importance of the nervous system in relation to the arrhythmias. That the hypothalamic centers are essential for the production of cardiac irregularities by injections of epinephrine in animals under cyclopropane anesthesia, was shown by the failure of appearance of the irregularities in dogs deprived of the function of the hypothalamus.

EFFECTS UPON HUMAN BEINGS

In human beings, cyclopropane administration is frequently associated with cardiac irregularities, especially in the third and fourth plane. Guedel⁸ has been able to cause disappearance of the ordinary clinical signs of these arrhythmias by increasing the cyclopropane concentration in the breathing bag from 50 to 60 per cent, together with passive respiration (controlled respiration). He reported, further, that induction of anesthesia, by means of intravenous pentothal or evipal, abolished or markedly diminished cyclopropane arrhythmias. This was in harmony with the observation by Robbins and Baxter⁹ that amylal protected the animal against the occurrence of cardiac irregularities under cyclopropane. Dikshit⁴ had also shown that barbital prevents chloroform-epinephrine arrhythmias.

COMMENT

It is then evident, first, that the hypothalamus is in some way involved in, or is essential for the production of cardiac arrhythmias under chloroform or cyclopropane; and, second, that depression of the hypothalamus, either by excessive doses of the inhalation anesthetic or by means of barbiturates, prevents the occurrence of the arrhythmias.

The nature of the arrhythmias is of interest. Seevers, Meek, Rovenstine and Stiles¹⁰ described a wide variety of types of arrhythmia. In our recent experiments¹¹ we observed principally bradycardia, ventricular extra systoles, ventricular tachycardia and nodal rhythm. These were prominent at concentrations of 25 to 40 per cent cyclo-

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From the School of Medicine, University of Southern California.

propane in the breathing bag. Arrhythmias of ventricular origin disappeared on increasing the cyclopropane concentration to 50 to 70 per cent. Nodal rhythm, however, when already present, persisted with these high cyclopropane concentrations, and, in two or three instances, appeared at the high gas concentrations when not previously present. Alterations in the T-wave in the dogs were usually associated with morphine premedication or with inadequate oxygen concentration in the breathing bag, and could not be related to the cyclopropane itself.

Except for the changes in the T-wave, the electrocardiographic phenomena are similar to those produced by sympathetic nervous impulses to the heart. As mentioned above, Meek, Hathaway and Orth⁶ showed that cyclopropane sensitizes the animal to the effect of epinephrine upon the heart. Because of the fact that both an intact hypothalamus and sympathetic pathway were shown to be essential for the production of cyclopropane-epinephrine arrhythmias, it is evident that some factor, in addition to cyclopropane and epinephrine, is related to arrhythmias, and that this factor is associated with a nerve reflex through the hypothalamus.

OTHER OBSERVATIONS

In a recent paper, Allen, Stutzman, Slocum and Orth¹² reported prevention of cyclopropane-epinephrine arrhythmias by sympatholytic substances (ergotamine, yohimbine, etc.) in doses which do not reverse the pressor action of epinephrine. Since, ordinarily, the dose of sympatholytic agent required to abolish the effect of epinephrine on the heart is much greater than that required to abolish its pressor effect,¹³ it would seem that these agents are acting by some other than their sympatholytic mechanism in preventing cyclopropane-epinephrine arrhythmias. Wright¹⁴ suggested that ergotamine in very small doses depressed certain vasomotor nuclei. Perhaps, then, these agents prevent cyclopropane-epinephrine arrhythmias through a central, rather than a peripheral action.

It is impossible at present to decide whether the arrhythmias produced by epinephrine in the presence of cyclopropane anesthesia have any relation to clinical cyclopropane arrhythmias. There is no information concerning the concentration of epinephrine in the blood in the various stages of cyclopropane anesthesia. It would seem, though, that administration of epinephrine during cyclopropane anesthesia is contraindicated, but that neosynephrine would be quite safe,⁷ since the latter does not produce arrhythmias of importance.

The question of the supposed toxic action of cyclopropane upon the heart is still controversial. Our experiments,¹¹ using bag concentrations of cyclopropane up to 75 or 85 per cent, in the absence of anoxemia, make doubtful the contention that cyclopropane, like chloroform, is a cardiac poison, or that nodal rhythm is a sign of impending ventricular fibrillation. Because of

other considerations, such as explosibility, as well as because of any theoretical danger to the heart, cyclopropane is an agent which should not be used by the unqualified person, but certainly in the hands of a well-trained and alert anesthetist, it can be used with relative safety, and for controlled respiration, it has no equal.

CONCLUSIONS

Arrhythmias under cyclopropane anesthesia are most marked at about apneic concentrations. Deepening the anesthesia with high concentrations (50-75 per cent) of cyclopropane in the breathing bag largely abolishes irregularities of the pulse and does not seem to increase the hazard to the patient. The indispensability of an intact hypothalamus for the production of the arrhythmias suggests that this structure, rather than the intrinsic cardiac tissues, is the site of action of the anesthetic agent in this regard.

3551 University Avenue.

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SALIVARY GLANDS: PATHOLOGICAL CONDITIONS AFFECTING THEM*

SAMUEL A. MORRIS, M.D.
Marysville

IN the practice of otolaryngology, cases with affections of the salivary glands constitute a small proportion of that practice. But not as little as the literature in the special journals of otolaryngology would have us believe. In reviewing the literature for presentation of this paper, the most striking feature was the limited amount of material to be obtained in the special journals.

INFLAMMATORY TYPES

In considering the inflammations first, a simple classification is presented to better orient ourselves.

Inflammations affecting the salivary glands:

1. *Acute Pyrogenic:*

Observed as a general post-operative complication, or in the course of a debilitating illness.

As an acute inflammation in the course of a chronic inflammation, following a duct obstruction.

2. *Chronic:*

As observed in duct obstruction by a calculus.

3. *Specific:*

Infectious parotitis

Tuberculosis

Syphilis

Actinomycosis

As a general surgical post-operative complication, the gland involved is invariably one of the parotids.

In the acute general infections, such as typhoid, typhus or pneumonia, or in any other debilitating illness, parotitis is not an extraordinary complication.

The teaching has always been that such a complication forebodes an inevitable disintegration. The mortality tables show that 60 per cent die when parotitis under the above conditions occurs.

However, Blair and Padgett reporting on a series of cases where free incision and early drainage was instituted, the mortality was only 26 per cent.

They recommend that, in mild cases, efforts to stimulate salivary secretion, and local application of hot or cold packs be used.

However, with marked local and constitutional signs, or after three days of conservative treatment in which no definite improvement is observed, free incision for adequate drainage and the relief of pressure is imperative.

After healing is complete, the final scar is insignificant. So report Blair and Padgett, and the justifications for this procedure is the low mortality rate of 26 per cent, which included some cases in their terminal stages.

SALIVARY CALCULI

In the chronic inflammations involving the salivary glands, the chief responsible agent is a salivary calculus.

Calculi occur most often in the submaxillary apparatus—about 90 per cent, less often in the parotid, and infrequently in the sublingual. Salivary calculi vary in size from minute particles to the largest on record, which is two inches in circumference by one and one-half inches long. They assume the larger proportions when occurring in the gland substance.

The etiological factors in their occurrence are said to be poor mouth hygiene, and/or a low grade infection in the gland system. A plug of bacteria or foreign material acts as a nucleus, about which the salivary salts precipitate. The stones are composed mainly of phosphates, with smaller amounts of organic matter, carbonates, calcium, and magnesium.

Symptoms depend upon which gland the calculus involves; the degree of obstruction produced by the calculus, and whether an inflammatory process succeeds upon the retained secretions.

In a consideration of the submaxillary calculi, I recall three cases that typify the varied symptomatology upon the conditions just stated.

REPORT OF CASES

CASE 1.—A woman in the thirties complained of pain in the floor of the mouth, and painful salivary enlargement on the right side at meal times, but not at all meals. Between meals the swelling would subside. Symptoms had been present for about six months. In the past several days, however, the salivary swelling had become larger, more painful, occurred with all meals, and did not completely subside between meals. A small calculus could be felt by combined extraoral and intraoral palpation, just behind the duct opening.

The duct opening was dilated with a lacrimal dilator; then one blade of a fine blunt tipped scissors was introduced into the opening, and the scissors closed. The calculus slipped out easily. The calculus was uneven and about 4 mm. in its widest diameter. The cut duct opening healed without stricture.

The explanation for her symptoms could be based on an inconstant ball-valve action of a small calculus; but as the calculus became larger it occluded the duct at its narrowest point, which is at the papilla.

CASE 2.—Was that of a woman of forty, who complained for several years that she could feel a hard object on the floor of her mouth. She confessed that, on occasion, the submaxillary gland would get a little larger. There was never any pain. Curiosity, rather than discomfort, obliged her to seek consultation.

The duct was incised over the stone, and the duct sutured with fine gut. It healed without a fistulous tract. Anesthesia used was local topical application of 2 per cent pontocaine.

This case illustrates that symptoms can be insignificant regardless of the size of the stone, as long as obstruction and infection do not supervene.

CASE 3.—The other case is that of a sixty-year-old male. He had been ill for four days with severe pain and swelling in the floor of the mouth. He had been unable to eat, because swallowing was painful. He had fever and appeared in great distress.

The floor of the mouth was acutely edematous, and so tender that examination was impossible. The right submaxillary gland was enlarged with a cervical adenitis on that side as well. The papilla of Wharton's duct on the right was edematous. Dental caries and pyorrhea were extreme.

Treatment immediately instituted was ice packs externally, and frequent hot mouth irrigations.

The next day a calculus could be seen to extrude

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through the duct about 20 mm. from the papilla. When picked out with a forceps, a gush of pus followed.

Recovery was rapid, complete and uneventful. However, a small fistula remains which is of no consequence.

COMMENT

This case illustrates the severity of the symptomatology following upon an inflammatory reaction. In this case, too, the importance lies in establishing a diagnosis. It could be confused with a cellulitis of the floor of the mouth attendant upon infected teeth, or an infection superimposed upon a malignancy, with metastases to the lymph glands. The important distinguishing features are:

1. A history of previous submaxillary gland involvement.
2. The absence of trismus will rule out a cellulitis of dental origin.
3. In carcinomatous metastasis to the lymph glands, the submaxillary glands would be fixed and indurated, whilst the submaxillary gland when enlarged due to a stone is not fixed, is deeper, and is elastic.
4. One of the most important points of differentiation is an x-ray picture demonstrating a stone.

FILMS

The proper technique for an x-ray of the anterior half of Wharton's duct is to place a film in the mouth, held between the upper and lower teeth in the occlusal plane and the x-rays directed beneath the chin. If the posterior part of the duct is to be filmed, the technique introduced by Samuel Iglauer is useful. The floor of the mouth is depressed with the index finger and a lateral film taken. This, of course, cannot be done when there is a severe inflammation of the floor of the mouth.

In filming Stenson's duct for a stone, the best position is an anteroposterior view, so as to avoid the shadow of the ascending ramus of the lower jaw. A small dental film in the mouth over the duct will, in some instances, more clearly demonstrate a calculus.

When calculi involve the gland substance proper, treatment consists in extirpation of the whole gland.

Infectious Parotitis.—Infectious parotitis should be mentioned in warning—because the name infectious parotitis limits the disease to the parotid. However, the disease may also involve the other salivary glands. An important diagnostic differentiation between infectious parotitis and other gland enlargement is found in a study of the leucocytes. In infectious parotitis the leucocyte count may be not at all or slightly increased, but the important difference is that there is a relative lymphocytosis and corresponding diminution of the polymorphonuclear leucocytes. Tuberculosis, syphilis, and actinomycosis are mentioned to denote their rare occurrence.

TUMORS

Compared to tumors elsewhere, those involving

the salivary glands are relatively infrequent.

For the purpose of correlating and presenting the material on hand in an orderly manner, the tumors have been classified as follows:

1. Mixed tumors.
2. Malignant: carcinoma, sarcoma.
3. Benign: adenoma, lipoma, haemangioma, lymphangioma, ranula, Mickulcz's disease.

I have placed the mixed tumors first, because of all the tumors that involve the salivary glands, about 95 per cent are of the mixed variety, of which about 75 per cent occur in the parotid.

There is no end of controversy regarding their etiology and even treatment.

They have been classified as benign mixed tumors and malignant mixed tumors. The differentiation is misleading and insecure, as the benign tumor of today may be the malignant tumor of tomorrow. The explanation for this lies in its derivation. Most embryologists and pathologists conclude that mixed tumors are the outgrowth of displaced buccal epiblast, from which the parotid is formed. It is, therefore, earlier than the embryonic parotid tissue and so includes mesoblastic elements—to explain the close association of cartilage, myxomatous tissue, and other structures of mesoblastic origin.



Fig. 1—Calculus from Salivary Gland (Case 2).

The histology of the mixed tumor because of its complexity is easily diagnosed microscopically. Beyond that, the microscope cannot reveal whether it will recur when removed or how it will terminate. There is no determining stage when a benign tumor is to become malignant. The conclusion must be reached that mixed tumors are inherently malignant in themselves, and do not, as is often described, undergo malignant degeneration.

A tumor appearing in one parotid in youth or young adult life, which grows slowly without pain or facial nerve involvement, and which does not involve the overlying skin, will most probably be a mixed tumor in its benign stage.

However, after ten years or more have elapsed, and when the tumor grows rapidly, causes pain, involves the facial nerve, and shows other evidence of infiltration, the mixed tumor is malignant.

McFARLAND'S STUDIES

Joseph McFarland, reporting on 278 parotid

mixed tumors collected from 27 hospitals, concludes:

"That 21.5 per cent recurred. Recurrences have been reported as late as 47 years after removal."

"There is no metastases and nothing happens unless there be traumatic injury to bring about ulceration, haemorrhage, or infection. Such being the case, there is no need for prompt surgical intervention, for the excision is too apt to be followed by facial palsy, which is a more distressing matter than a lump on the cheek."

Another matter of importance and one in which mixed tumors seem to differ in that recurrence is more frequent when the tumor removed is small.

It appears from McFarland's conclusions, though he does not so conclude, that once a diagnosis of mixed tumor is made, any recurrence following its removal warrants complete extirpation of the gland regardless of the ensuing facial palsy. Those are the opinions of the majority of skilled tumor surgeons.

OTHER TYPES

Carcinoma or sarcoma of the salivary glands is rare. They arise in the adult parenchyma, as distinguished from the mixed tumor, which obtains its origin in extra-parenchymal tissue.

The diagnosis features in its main a small hard lump, generally arising in the parotid of an adult usually over forty. It is painful, fixed, grows rapidly, and displays infiltrating characteristics early. They also have a tendency to distant metastases, e.g., to the lungs and bones, as distinguished from mixed tumors, which are locally malignant. In the benign group, the adenoma and lipoma cannot be distinguished from the mixed tumor except microscopically. They are rare diseases.

The most frequent benign tumor involving the parotid is the haemangioma. It is seen at birth or very soon thereafter. The diagnosis is simple, as the haemorrhagic tumor appears only in children. The contents of the tumor can be expressed, which, of course, immediately refills when pressure is released.

Lymphangiomata.—Lymphangiomata occur less frequently, and are distinguished by their color, and the inability to empty them by pressure.

Treatment is by excision or radiation.

Ranula is a submucous cystic swelling taking origin in the sublingual gland division. It appears in the floor of the mouth anteriorly, and may attain large enough proportions to interfere with movements of the tongue.

Mickulicz's Disease.—Mickulicz's disease proper consists in the symmetrical, painless, non-inflammatory enlargement of the lacrimal glands and one or more pair of salivary glands. There is no involvement of the lymphatic system or alteration of the blood. The general health of the patient is good. The histology is that of lymphocytic infiltration.

Treatment by radiation has been very successful.

Mickulicz's disease proper should be distin-

guished from Mickulicz's syndrome, in which the enlargement of the glands is due to some other well-defined disease, such as leukemia, syphilis, tuberculosis, Hodgkins, or lymphosarcoma.

In conclusion, I daresay that diseases of the salivary glands make up a larger proportion of otolaryngological practice than is realized. Affections of the salivary glands deserve more space in the literature devoted to otolaryngology.

725 Fourth Street.

VARICOSE VEINS: A SUGGESTED OPERATIVE PROCEDURE*

AN OPERATION FOR VARICOSE VEINS BASED ON ANATOMICAL STUDIES OF INCOMPETENT THIGH PERFORATORS

R. STANTON SHERMAN, M.D.
San Francisco

MUCH as recent advances have improved the diagnosis and treatment of varicose veins, it is still not possible to obtain ideal results in a considerable number of cases because the diagnostic methods available are not precise enough to disclose the exact location of all incompetent or potentially incompetent perforator veins. Although the ligation and division of the main saphenous vein and its branches at the sapheno-femoral junction are well standardized, the destruction of the perforator veins of the midthigh is often unsatisfactory because, as usually employed, it depends on a blind searching which often fails to produce the desired results.

Because these deficiencies in diagnosis and therapy of incompetent thigh perforators were frequently observed, studies were made on one hundred and twenty-eight patients who had had long saphenous vein ligations combined with retrograde injections of a sclerosing solution. The results of these are shown in Table A. It is to be noted that, while much improvement was obtained by 53 per cent of patients, in 47 per cent the procedure left much to be desired. Indeed, in many cases, the failure was so obvious that further operative therapy was necessary.

The fact that the elimination of incompetent thigh perforators is often inadequate led me to make further anatomical studies on nineteen cadavers, which disclosed some interesting and hitherto undescribed anatomical findings. This led me to alter the surgical technique employed in the treatment of varicosities.

ANATOMICAL STUDIES

The perforator veins connecting the saphenous and the femoral systems are quite variable in number and in location. Nevertheless, there are certain rules which nearly always apply. For

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From the Division on Surgery, University of California Medical School.

Figure I. Type I. Cadaver 12

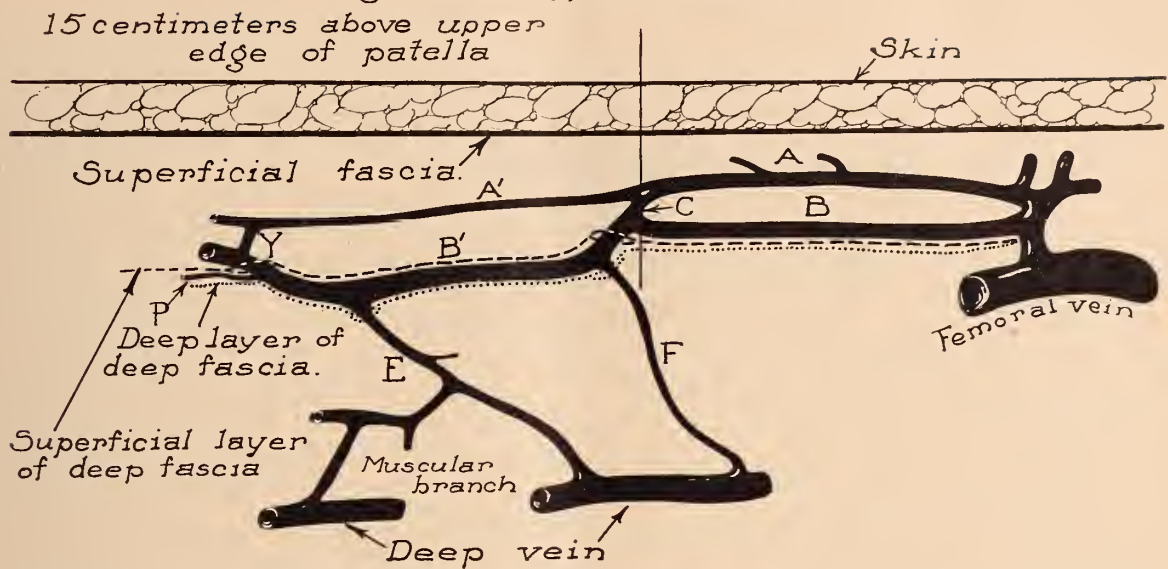


Fig. 1.—Type I: From Cadaver Dissection. The main stems of the saphenous system are shown as AA' and BB'. Note that proximal to connector Vein C, Vein B lies superficial to the superficial layer of the deep fascia, and that distal to Vein C, Vein B' lies between the fascial layers. Perforator veins are shown coming off from Vein B'.

example, the sapheno-femoral junction in the groin is a constant finding. Moreover, there appears to be a basic pattern in the development of the long saphenous stem which is subject to minor variations, and which in large part governs the location of the thigh perforator veins. According to my studies the common embryonic pattern of the saphenous system appears to consist of two saphenous stems in the thigh (Type I,

Fig. 1), and while both of these veins are found in the expected location superficial to the deep fascia in the upper thigh, the main saphenous vein pierces the superficial layer of the deep fascia in the midthigh area, whereas the accessory vein remains superficial throughout its entire course (A, A'). The vein which runs beneath the superficial layer of the deep fascia (B') assumes great importance, because it is from this vein

Figure II Type II Cadaver 7.

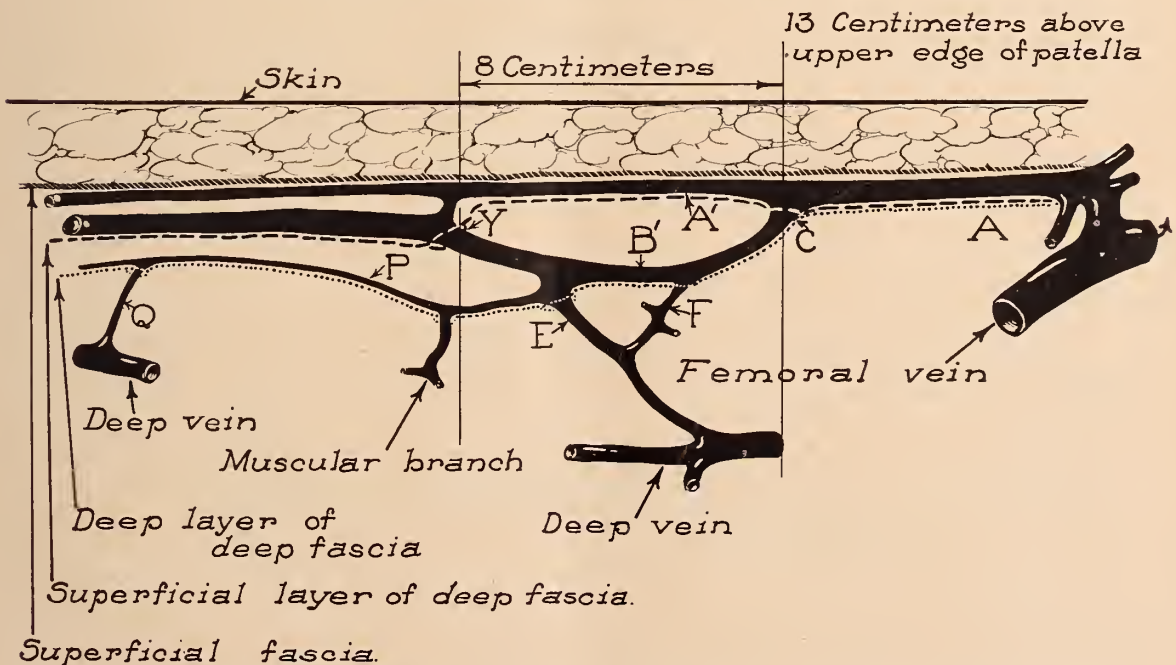


Fig. 2.—Type II: From Cadaver Dissection. Note that Vein B is absent. The branch P from Vein B' gives off an additional perforator vein (Q).

Figure III. Type III Case 97

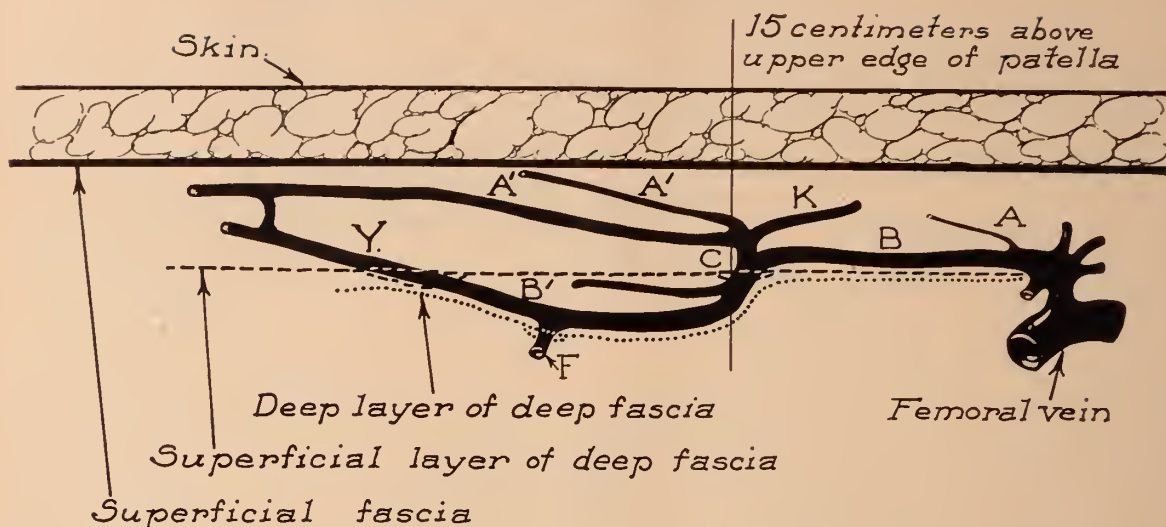


Fig. 3.—Type III: From Surgical Dissection. Note that Vein A is rudimentary.

that the main perforator branches which connect with the deep veins of the thigh arise (E, F). After coursing down the leg for five or more centimeters this saphenous vein usually branches again. One branch emerges from beneath the superficial layer of the deep fascia (Y) to re-occupy its position superficial to the deep fascia, while the other branch (P) continues down the thigh and leg between the deep fascial layers. Despite careful search of the anatomical text books and the literature of this subject, no mention of this relationship of the saphenous vein to the deep fascial layers has been found; yet, obviously, utilization of this knowledge would do much to improve the treatment of thigh perforator deficiencies. Figure 5 shows the relationship of the two saphenous stems to the superficial layer of the deep fascia in the fetus.

From a study of nineteen cadavers and over one hundred operative cases, it appears that this

general pattern shows three variations in type (Type II, III, IV). Type II (Fig. 2) is the same as Type I, except that Vein B is absent. Type III (Fig. 3) is also the same except that Vein A is absent. Type IV (Fig. 4) is again like Type I, except for the apparent absence of Vein A'. No case has been observed in which Vein B' is absent. Any of these veins may be double or even triple, and considerable variation has been observed of the manner in which branches connect them with the deep circulation. The crux of the entire treatment of incompetent thigh perforators depends, therefore, on a full realization of the importance of this pattern, and especially of the rôle played by Vein B'. The elimination of all these veins—A, A', B, B' and P—should prevent reflux flow of blood from the deep veins of the thigh by severing those incompetent veins which communicate between the deep and superficial system.

Figure IV. Type IV Case 132.

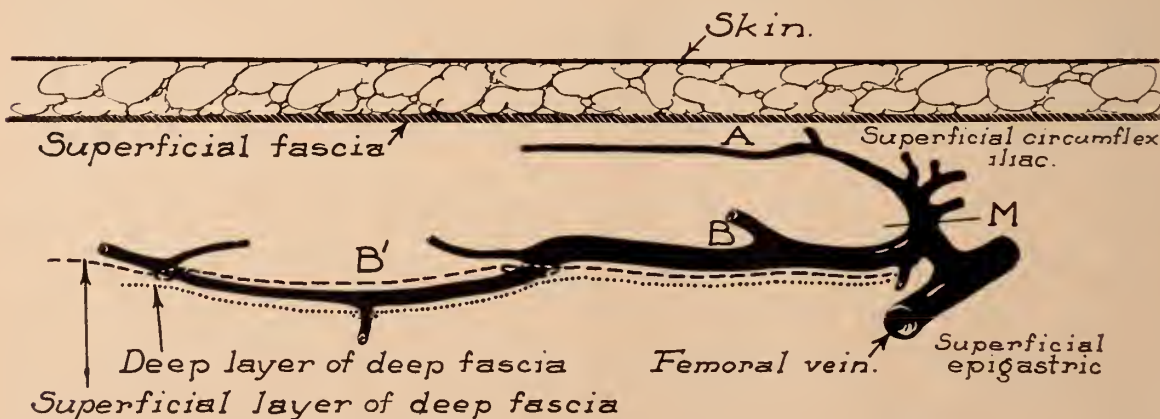


Fig. 4.—Type IV: From Surgical Dissection.—This figure illustrates danger of mistaking a superficial vein (A) for the main saphenous when ligation of the saphenous vein alone is practiced. (See text.)

SURGICAL APPLICATIONS

With the vein arrangement shown in Fig. 1, an ordinary Mayo stripping procedure and ligation of Vein A, would eliminate Vein A and A', and disconnect the upper part of Vein A from the femoral vein; but the Veins B, B', C, E and F would remain open and, if incompetent, would prevent a satisfactory result. If, however, Vein B and B' and Vein C were also excised, one would expect marked improvement because, aside from the ligation of the saphenous vein at the sapheno-femoral junction and elimination of Veins A, A', B, B' and C, the Veins E and F would also be severed.

In Fig. 2, another problem is presented. Here the Mayo stripping of Vein A and A' would sever Vein C, but would not eliminate the branches E and F which also connect the deep veins of the leg. However, if Vein C, B' and P were excised by the stripping procedure, branches E, F and Q would be cut across. This would definitely aid in eliminating the reverse flow of blood in the incompetent thigh veins. Thus, it becomes apparent from cadaver dissections, that Vein C and B' are of great importance, for most of the veins connecting with deep system are branches of Vein B'.

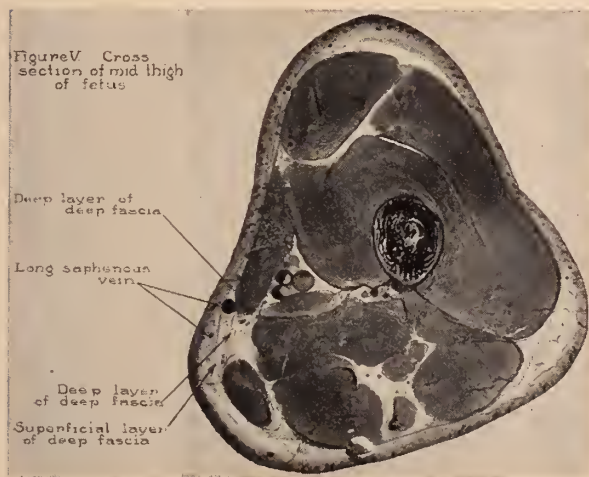


Fig. 5.—Cross Section of Midthigh of Fetus. Note the two stems of the saphenous system which are separated by the superficial layer of the deep fascia.

The surgical approach is based upon the information yielded by the anatomical studies which have just been described, a procedure which, in my hands, has materially improved the results of varicose vein therapy. Moreover, it involves a minimal amount of trauma and has the advantage of keeping patients in bed for only short periods of time. It consists of a combination of vein injection, high saphenous vein ligation and vein stripping. The basically-new approach is the employment of sclerosing solution as an agent for the suppression of hemorrhage from the long saphenous vein and its branches, so that vein stripping can be performed without the danger of

postoperative hemorrhage. Patients can be out of bed and active within twenty-four hours. This early activity combined with firm thrombosis of the cut veins also reduces the danger of lung infarcts by emboli.

TABLE A.—Results of Studies on Cases Treated by High Ligation and Retrograde Injection of Sclerosing Solution

Total cases examined.....	123
Total number of legs.....	190
Number of faulty high ligations.....	9 legs
Average elapse of time since operation.....	2.6 years
*Reflux flow of blood in 0—15 sec.....	89 legs—47%
*Reflux flow of blood in 16—40 sec.....	101 legs—53%
*75—100% improvement.....	96 legs—51%
*50—75% improvement.....	44 legs—23%
*Under 50% improvement.....	50 legs—26%

*Multiple tourniquet test were employed and observations were taken with tourniquet applied at groin, so as to rule out any inaccuracy of the high ligation procedure.

OPERATIVE PROCEDURE

Varices below and slightly above the knee are thoroughly sclerosed by local injection. Under local, spinal, or general anaesthesia the sapheno-femoral junction is exposed through a longitudinal incision. When the long saphenous vein is identified, a temporary ligature is applied and the vein is subjected to the retrograde injection of a sclerosing solution. An interval of ten to fifteen minutes is then allowed to elapse, during which time the saphenous vein and its upper branches are exposed, ligated, and divided. This procedure of high ligation of the saphenous vein is now so fully standardized, that comment on this aspect of the operation is unnecessary.¹ At the end of this interval of time, it will be found that the sclerosing solution has caused thrombosis in the affected vessels, which usually prevents bleeding when they are cut across. It is important, however, to test the effectiveness of the sclerosis by releasing the temporary ligature and observing that bleeding does not occur from the open end of the vein. If, in rare instances, bleeding should occur, the vein is again subjected to an injection with sclerosing solution. It may be stated here, that the effectiveness of sclerosis as a hemostatic agent is in direct proportion to the ability of the sclerosing solution to injure the intima of the vein. If, in any case, there is a doubt that the sclerosis effectually suppressed all hemorrhage, the offending vessel should be ligated or, if perchance the bleeding vessel cannot be located, firm bandaging of the leg should control any bleeding.

TABLE B.—Classification According to Types

Total cases operated.....	43
Total number of legs.....	67
Number of legs, Type I.....	7
Number of legs, Type II.....	41
Number of legs, Type III.....	3
Number of legs, Type IV.....	16

The next step is the elimination of the thigh perforators. Although Vein C is usually located

within a distance of twelve to twenty centimeters above the upper edge of the patella, its exact position is quite variable. Three procedures have been found helpful in locating it. First, the midthigh area is inspected to ascertain if a dilated bulbous varix is present. If so, Vein C is extremely likely to be near it. Secondly, a small looped Mayo stripper or a Babcock probe may be inserted inside the vein and forced down until obstruction is encountered. Third, a Mayo stripper may be placed outside the vein, the vein being stripped caudally until rather marked resistance is met. (In the latter case, the superficial femoral branches of the saphenous vein must not be confused with Vein C.) Vein C is usually found at this point of resistance. When it is located a longitudinal incision about 7 cm. in length is made over the area. Vein C is identified and separated from Vein A. Once identified, it is simple to ascertain the fact that Vein C pierces the fascia. In fact, in order to strip Vein C and B', it is usually necessary to direct the loop of the Mayo stripper cephalad in order to engage Vein C through the opening in the superficial layer of the deep fascia. Vein A' and Vein C and the latter's continuation B' are then excised by stripping to a point at least ten centimeters below the knee. From operative cases it appears that the Veins P and B' below point E vary in size and importance in different cases (Fig. 2). If one of these is large, the other is usually small. The Mayo stripper tends to follow the larger vein, so that while in some cases the stripper below point Y will run above the superficial layer of the deep fascia, in others it travels under this fascial layer.

Two examples illustrate some of the technical problems encountered. Occasionally, as in Fig. 4, Vein A is found supplying only the upper thigh, and stripping fails to trace it beyond the midthigh, in which event one may expect to find Vein B of substantial size. Here connecting Vein C may exist, but is so small that its identification is impossible. Also it is very important to note that Vein B could easily be mistaken for the femoral vein, and hence, should a ligation be performed as indicated by line M, the procedure would leave Vein B patent and the operative procedure would fail to accomplish its purpose.

Fig. 3, depicts an interesting variation. The pattern of the veins is nearly opposite to that shown in Fig. 2. It is seen that Vein A is only rudimentary. The area usually supplied by Vein A is probably drained by the superficial circumflex iliac above and by the ascending continuation (Vein K) branch of Vein C, below. Vein B descends to a point fifteen centimeters above the upper edge of the patella where it divides into several branches. One of the branches from Vein C immediately divides into three superficial veins. One branch (Vein K) representing Vein A, ascends toward the upper thigh, while two branches (representing Vein A') take a downward course. Incidentally, Vein B' is also represented by two veins, one of which is much smaller than its partner.

DISCUSSION

The recognition of the occurrence of anatomical Types I, II, III and IV has grown, as stated, from observations on over one hundred Mayo stripping operations performed between August 1, 1940 and September 1, 1941, and from dissections of nineteen cadavers. Since these types have been clearly recognized, forty-three additional cases have been operated upon. Their type distribution is shown in Table B. In this preliminary report, no attempt has been made to indicate the late effects of the procedure, since insufficient time has elapsed for proper evaluation. It would appear, however, that the method should reduce the incidence of recurrence. It is interesting that in the entire group of 146 cases no massive hematomas, and no pulmonary embolisms have occurred.

SUMMARY

1. It is shown that a general scheme of arrangement of the saphenous system in the thigh exists and that variations are common.
2. The occurrence of a heretofore unrecognized location of the saphenous vein between deep fascial layers, and of more or less constant connecting veins perforating the deep layer of the deep fascia in the midthigh, is described.
3. Suggestions are made for what appears to be a more effective operative therapy.
4. These anatomical variations seem to be divided into four main types whose surgical significance is emphasized.

516 Sutter Street.

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TYPHUS FEVER IN CALIFORNIA*

WILTON L. HALVERSON, M.D.
Los Angeles

IN his very entertaining and instructive story of typhus fever, which he entitled "Rats, Lice and History," Hans Zinsser quotes from the Cronica Cavense, an Italian manuscript, what is perhaps the earliest known record of typhus fever.

"In the year 1083, in the monastery of La Cava (near Salerno), in the months of August and September, there spread a severe fever with peticuli—and parotid swellings, in which one sees clearly the difference which is found from the Pest, a fever of a different kind and—in this case—accompanied by petechial spots."¹

Typhus fever is accurately described by Girolamo Fracastoro in his treatise on Communicable Disease, *De Contagione*, published in 1546. It has played a major rôle in history, and time after time has dictated the outcome of war, not always favoring the strong. The causative agent is *Rickettsia prowazeki*. There are two forms: the

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From the Los Angeles County Health Department, and the Division on Public Health of College of Medical Evangelists.

epidemic, Old World louse-borne disease; and the endemic flea-borne, murine variety.

Epidemic typhus is nearly always associated with war, famine and oppression. It strikes when mankind is in the depths of misery and wretchedness, when society is already disorganized.

Charles Nicolle, in 1909, discovered that epidemic typhus is spread by the body louse, *Pediculus corporis*, by direct transfer from one human to another, and thus gave man his first advantage in the unequal combat. As far as is known, man is the primary host, although the disease may be kept alive in rodents during inter-epidemic periods. The body louse, while not now prevalent in many parts of the civilized world under normal conditions, quickly multiplies under abnormal conditions which favor filthiness and malnutrition.

EPIDEMIC AND ENDEMIC TYPHUS

There were two severe epidemics of typhus in Europe during and shortly after World War I. In Serbia, in 1915, typhus caused 150,000 deaths, and in Russia in 1916-1922 there were tens of millions cases and millions of deaths. No accurate records were kept.

The other type, endemic, flea-borne or murine typhus, has not occurred in epidemics. It is sporadic in nature, with greatest incidence in late summer and fall, in contrast to the epidemic type which is more prevalent in winter. It was shown by Dyer and his associates of the U. S. Public Health Service, in 1931, to be spread by the rat flea *Xenopsylla Cheopis*.² The primary host is the gray rat and possibly other rodents. In the United States it was first diagnosed in 1913 by Paullin in Atlanta, Georgia.³

During the past decade, cases have increased in numbers in the United States until in 1941, 2,780 cases were reported. The disease in California cannot at present be considered serious from the standpoint of numbers of cases or severity, but the prevalence of rats in most sections makes it a potential menace. This is especially true in light of troop concentrations, defense activities and possible military operations.

The exact relationship of epidemic to endemic typhus is not known. Serologically and immunologically they are not distinguishable.⁴ There is reason to believe that murine typhus, transmitted to man by the rat flea, may become epidemic, and in recent years murine infection has been found in areas where epidemic typhus prevails.

The relationship of Brill's disease, which was first recognized in New York in 1898, is not definite. It resembles endemic typhus in that it seems to have no relation to louse infestation, is not transmitted from person to person, and has a seasonal prevalence similar to the cases reported in southeastern United States.⁴ Attacks occur most commonly in immigrants who have had typhus fever years previously in the Old World, and may be recrudescences of previous infection.⁵

Typhus fever is distributed widely throughout the world. The epidemic variety is found in Europe, Asia and Africa. The endemic type is

found principally in the New World, the Mediterranean basin and in the East Indies, a present seat of world conflict. It is also scattered in other sections. Table 1 indicates the increased incidence of typhus in certain areas of Europe and North Africa, in 1941. In spite of this data, Dyer does not believe that typhus fever will be a serious problem in Europe in the immediate future.

TABLE 1.—*Typhus Fever in Certain Countries of Europe and Africa: 1940-1941*

Place	Cases	
EUROPE	1940	1941
Bulgaria	155	284
Germany	230	2,158
Poland		3,786
Spain	14	9,560
Turkey	533	704
AFRICA		
Algeria	2,146	12,827
Egypt	3,636	9,324
Morocco	355	1,471
Tunisia	651	7,078
Union of South Africa.....	298	780

TYPHUS IN THE UNITED STATES

In the United States typhus fever has been reported principally from the southeastern states and California. It is possible, however, that cases may be missed in areas where it is not expected. Therefore, patients with influenza-like symptoms, who develop a discrete maculopapular rash not consistent with the common exanthemata from three to six days after the onset, should be suspected of having typhus and diagnostic laboratory checks carried out.

Chart II indicates a rapid increase of the disease in the United States during the past decade. The factor of more common recognition probably accounts for a proportion of the increased reports, but the variations in trend indicate that this is not the only factor. Endemic typhus is probably a comparatively new disease in this country.

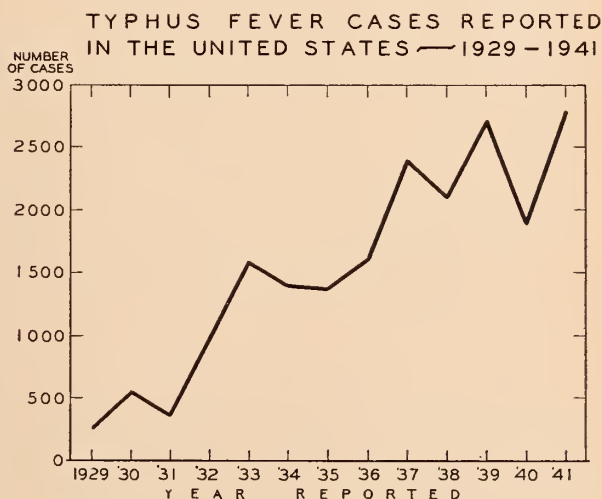


Chart II

In California typhus fever was reported as early as 1916. From that time to April, 1942, 229 cases have been reported. Of these, 157 were

from Los Angeles County. Chart III shows a period of increased incidence of reported cases in California from 1921 to 1924 and again from 1936 until the present time.

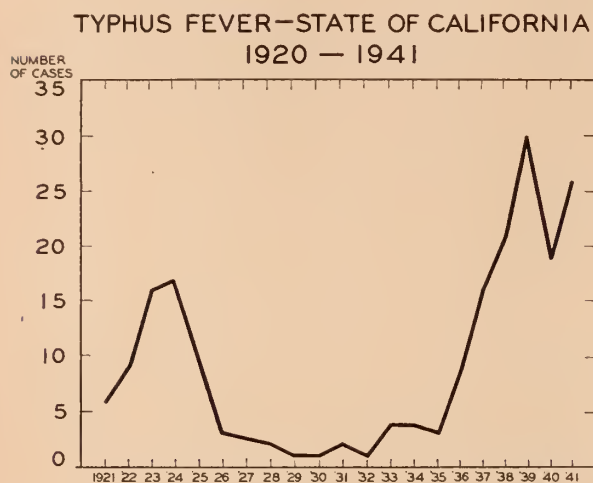


Chart III

Thirty-seven cases of typhus fever were hospitalized in the Los Angeles County Hospital from July 1, 1939 to April 1, 1942. A study of these cases shows no great variation from the clinical picture of cases reported from the southeastern section of the United States.

In California endemic typhus is more prevalent in the last three months of the year. In the southeastern part of the United States the period of greatest incidence is somewhat earlier.

Endemic typhus is three times as common in males as in females, and is more prevalent in adults of active working age than in children or the aged. It occurs most commonly in those who live or work in close proximity to rats.

From the standpoint of control, epidemic and endemic typhus must be regarded as distinct entities. In the one case, the eradication of rats is the solution. In the other, frequent delousing and scrupulous cleanliness is of prime importance.

The California State Department of Public Health has inaugurated a typhus fever survey. At the present time the Los Angeles County Health Department is carrying out a rodent control project. Rats are being taken alive, combed and the fleas sent to the Hooper Foundation laboratory for checking. Thus far no rickettsia have been isolated.

VACCINATION

Typhus fever can be prevented by immunization, but thus far no vaccine has been used extensively enough to be of proven merit. Vaccines are of two types, live and killed. Live vaccines have been developed by Nicholle and other workers. They will prevent typhus, if properly prepared, but have been largely discarded because of the danger of producing serious attacks of the disease.

Killed vaccines, utilizing the louse as the agent

to multiply the rickettsia, have been prepared and described by several investigators, including Weigl.⁷ He inoculated lice by rectum, and allowed the lice to feed on immune humans in order that the rickettsia might multiply, then dissected out the intestines which, after preparation, constituted the vaccine. One hundred lice are required for a dose sufficient to immunize one person. This method, impractical for immunizing the general population, might be utilized for protecting nurses and doctors in time of epidemic.

Zinsser⁸ prepared vaccines by growing the rickettsia in the peritoneal cavities of rats, which had been subjected to preliminary injections of benzol and olive oil, or to preliminary x-ray treatment. He also used vitamin deficient guinea pigs in the same manner with good results.

In 1939, Castaneda⁹ reported a method of multiplying rickettsia by the intranasal inoculation of endemic strains in rats and mice. This results in a rickettsial pneumonia and produces enormous numbers of organisms. Formalized emulsions produce immunity against infectious doses of similar strains both in animals and in man. Other investigators have produced vaccine by this method, using epidemic strains.

Cox,¹⁰ of the U. S. Public Health Service, reported preparation of a vaccine from rickettsia grown in the yolk sac of a seven-day chick embryo. Five to seven days later, upon the death of the embryo, the crop of rickettsia is harvested and prepared.

Meyer¹¹ has stated that the Castaneda vaccine offers the most practical promise of effective protection, and Dyer¹² indicates that both the Castaneda and Cox vaccines should be effective. Both are under extensive clinical trial in South America and Europe at the present time.

CLINICAL OBSERVATIONS

The incubation period of endemic typhus varies from six to fourteen days, as shown by laboratory investigation and where a history of flea bite is obtainable. In the thirty-seven cases studied at the Los Angeles County General Hospital, only one patient was aware of having been bitten by fleas. In this instance the period between the flea bite and the onset was fourteen days.

The onset is usually abrupt with fever, chills, severe headache, and generalized muscular aching. In mild cases the onset may be gradual, with malaise and increasing fever. Bronchitis, with severe coughing, may be present. There is often photophobia. Lethargy and mental apathy is marked in severe cases. Delirium may be present. Gastro-intestinal upset, with vomiting and diarrhea or constipation, may occur. In most instances the temperature reaches a peak of from 101 to 105 within the first week of the disease. It remains elevated from ten to sixteen days, then usually falls rapidly.

Until the characteristic rash appears on the fourth or fifth day, the diagnosis is usually thought to be influenza. If the patient is under careful observation, the first macules will usually

be seen on the chest, and from this location they spread over the abdomen and back and on to the extremities. The lesions are less common distally, and are rarely found on the palms, soles and face. The lesions are usually flat, but may be slightly elevated. They vary from 1 to 4 mm in size, and when they first appear are usually pinkish in color. In severe cases they tend to become purpuric or may be purpuric from the beginning. The duration of the rash is from three days to two or three weeks. In general, it tends to be transient in mild cases.

LOS ANGELES CASES

In the thirty-seven patients who were under observation at the Los Angeles County Hospital, the onset was abrupt in twenty-four instances and gradual in thirteen. Thirty-two of the thirty-seven reported chills at the onset. In fifteen instances this symptom was present for the first four or five days of illness. The maximum temperature ranged from 101 to 105.6, with an average of 103.5.

Every patient except one reported headache as a prominent symptom. In many instances the headache was described as heavy, frontal, or bilateral, continuous and very difficult to relieve. Twenty-two patients reported generalized aching, in most instances of the large muscles. Backache was present in fifteen cases.

Six of the thirty-seven afflicted were markedly apathetic or stuporous, and in two instances delirium was present.

Gastrointestinal symptoms were relatively infrequent. A dry, dirty, sordid mouth was an annoying feature of three severe cases. Nine patients reported vomiting, and in four additional instances nausea was present. In five instances diarrhea was noted and in three instances marked constipation was mentioned.

The rash was seen most commonly on the fifth day of illness. In eight patients it was not noted until the seventh, eighth or ninth day; but in each of these cases the patient was hospitalized on the day the rash was first seen. The rash was variously described as macular, maculopapular and discrete; and in color, pink to deep red and purple. In most instances it was much more prominent on the trunk and on the proximal parts of the extremities. In only two instances did it appear on the palms and soles.

The white blood count is usually not elevated in endemic typhus. Of the thirty-seven cases studied, sixteen had counts below 7,500 and in only eight cases was the count above 10,000.

The Weil-Felix test, using *Proteus* strain, OX₁₉, was carried out in all cases. The maximum positive titre ranged from 1/40 to 1/20,480, with an average of 1/1280. In eight instances the titre did not reach 1/320, but in the majority of cases it had passed this level before the tenth day of illness. Dr. Dyer¹² emphasizes the specificity of the complement fixation test as developed by Bengtson,¹³ using rickettsia grown by the yolk-

sac method as the antigen. This test is specific, and differentiates Rocky Mountain Spotted Fever which cannot be differentiated from typhus by the Weil-Felix reaction. The symptoms of epidemic typhus are of the same nature, but much more severe.

DIAGNOSIS

The disease most commonly in this country confused with typhus fever after the rash appears is Rocky Mountain Spotted Fever. Both diseases are caused by rickettsia. The prodromal symptoms are similar, and in both a rash occurs several days after the onset. In Rocky Mountain Spotted Fever, however, the disease most commonly occurs in spring and early summer. There is usually a positive history of tick bite, the clinical course is much more severe, the white count is usually elevated, and the rash is more pronounced on the extremities and is commonly found on the face, hands and feet. The diseases can be differentiated by the complement fixation test or animal inoculation.

Measles may be confusing in those cases in which photophobia occurs as a prodromal symptom. Those cases having a gradual onset may be differentiated from typhoid fever by blood culture and agglutination tests. As has already been noted, the preëruptive stage is very similar to that of the early case of influenza. In the Tropics, malaria must be differentiated.

COMPLICATIONS AND TREATMENT

The complications of typhus fever of the endemic type are rare. Bronchopneumonia is the most frequent and occurs most commonly in the aged. In the thirty-seven cases studied, bronchopneumonia occurred twice and lobar pneumonia once. Other complications, none of which occurred in the group studied, include phlebitis, acute myocarditis and thrombosis. Gangrene of the skin is common in epidemic typhus.

The treatment of endemic typhus is symptomatic. Convalescent serum has been used, but probably is not of great value. In severe cases good nursing care is of prime importance.

The case fatality rate of endemic typhus fever is low. No deaths occurred in the group studied. In the 229 cases reported in California since 1916,¹⁴ there have been five deaths, or a rate of 2.2. The case fatality rate for the United States for 1940 was 5.2 per cent. Most deaths occur in the aged.

SUMMARY

Typhus fever of the endemic type is prevalent in southeastern United States and occurs in California. 2780 cases were reported in 1941.

Typhus fever is spread widely over the world, and in Europe epidemic typhus is increasing. The disease presents a grave potential danger in the light of present conditions.

Prevention by vaccination is in the trial stage, and favorable results are anticipated.

Thirty-seven cases hospitalized in the Los Angeles County Hospital were studied. Clinical symptoms are influenza-like, with a superimposed maculo papular rash appearing the third to the sixth day. The case fatality rate of endemic typhus averages less than 5 per cent.

800 North Spring Street.

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CLINICAL NOTES AND CASE REPORTS

MEDICAL AID IN THE U.S.S.R. ARMY*

CHARLES L. RUBENSTEIN, M.D.
San Francisco

IN a previous article published in *CALIFORNIA AND WESTERN MEDICINE*, in December, 1941 (page 304), I quoted from the well-known Doctor Burdenko who stated that total warfare, as carried on today, has transformed medical service in the army to an extent heretofore undreamed. Indeed, modern war creates innumerable problems different from those encountered during periods of peace.

Total warfare brings with it casualties previously unknown. Thermal injuries, blast and crush injuries, such as the nomenclature of modern multiple wounds, with marked tissue destruction and contamination resulting in early virulent sepsis. Considerable attention was paid to the prevention of frostbite in the Russian counter offensive which took place last winter. Brigadier Surgeon Professor Gorinevskaya emphasizes the fact that she does not know of a single case of a wounded man contracting frostbite during evacuation. The use of heated ambulances, as well as frequent and warm feeding stations set up along ambulance routes, reduced

frostbite casualties tremendously. Soldiers at the front afflicted with frostbite were treated by the open section method, with the help of physiotherapy, and with prophylactic injections of anti-tetanus serum.

There is no question but that the difficulties and complexities of modern warfare require a streamlined, efficient approach. How well the Red Army medical service is coping with the situation is illustrated in an article written by the same Brigadier Surgeon Gorinevskaya. She relates that the Red Army medical service has an extensive network of medical and surgical set-ups on evacuation routes with highly qualified physicians in charge of each of these stations. Medical personnel is trained to render adequate care under any condition, in tents, huts, dug-outs, etc.

Many lives have been saved by supreme devotion on the part of medical personnel and the civilian population. Its blood transfusion service is indeed a bright page in the history of Soviet military medicine. It has blood banks in practically every city. Blood in thermostats is speedily dispensed by airplane to any emergency point. Obviously, rapidity is essential in reducing death from anaerobic gas-infection by timely injection of prophylactic and curative serums, and by surgical intervention. As a result of this treatment, 70 per cent of hospitalized wounded have been restored to active duty.

The heroism of the doctors has been noteworthy. For example, once while Professor Vichnevsky was operating on an army officer, an enemy plane shot the officer in the leg. The surgeon calmly completed the original operation, then immediately proceeded to the second and extracted the bullet. This doctor also drew blood from his own vein during an operation in order to save the life of a young girl injured when an air-raid shelter was blown to pieces by a direct hit.

It is interesting to note that Soviet hospitals are highly specialized, each receiving casualties of a particular type of wound. Such specialization has been fully justified. Figures show that, compared with the war of 1914-18, death casualties from all causes in the present war have dropped 33 per cent. Casualties from head, jaw and thorax wounds have dropped 50 per cent, and those from injury to the spinal column 80 per cent.

In spite of being tremendously overworked, Soviet doctors have never lost their interest in scientific work. Conferences are frequently held, experiences exchanged, analyzed, summarized and, as a result, form a sound basis for the development of field surgery. Doctor Yudin recently reported a method of treating brain concussion that resulted in complete recovery in the majority of cases. Military Surgeon Shefter reported treatment of severed nerves by grafting specially-treated segments of animal nerve tissue. Dr. Davidov invented a method of freezing blood plasma for transportation and storage. Professor

(Continued on Page 175)

* Information contained herein has been secured through personal correspondence with Russian colleagues, from Russian medical journals, and from the "Information Bulletin" of the Embassy of U.S.S.R.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section, on pages 2, 4 and 6.

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CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals: For Colleagues in Military Service

In this issue appears editorial comment on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in cooperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

This notice will appear in this department every month.

If you have not read the editorial outline of the plan in the September issue, you are urged to do so.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals to: C. M. A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California.

Procurement and Assignment Service

Recruitment of medical officers for both Army and Navy services was given added impetus late in August, when local draft boards were advised that no further deferment should be granted registrants because of the fact that they had applications for commissions pending. Although this order is not directly aimed at physicians and dentists, there has been some indication that the large number of men in these two professional groups who were making applications for commissions were indirectly responsible for the writing of the new regulation.

Here is what has been happening in far too many cases: a physician makes initial application for a commission in the Army or Navy medical corps. He completes the preliminary application blank, takes his physical examination and receives a clearance from Procure-

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (Federal 1953).

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

† For complete roster of officers, see advertising pages 2, 4, and 6.

ment and Assignment Service on his availability. Then he delays in completing his application for commission by not filing with the recruiting office the necessary documents to accompany his application. In this way he may truthfully say that he has an application for commission pending, while in fact he has done nothing more than to complete the preliminary steps for securing a commission.

One such case has been uncovered where the applicant failed for five months to complete his papers. Needless to say, when Procurement and Assignment Service found this situation there was little sympathy given the applicant.

Now the power of Procurement and Assignment Service to defer the induction of physicians because of pending applications for commissions has been withdrawn. Each physician is now on his own with his local draft board on this score. Procurement and Assignment Service has notified every physician on the "available" list of this change of procedure by the local draft boards; it will now be up to the men themselves to work out their own salvation with their local boards.

Aside from this new development, the recruiting program is proceeding on orderly lines. The Army is still seriously short of medical officers and can use all possible applications for commissions. The new draft board order is expected to produce a large volume of applications.

Procurement and Assignment Service is just now beginning to receive the data necessary to compile and put into operation a relocation file for the filling of vacancies in medical practice in industrial plants or in civilian communities. It is hoped that through this file there may be supplied enough physicians to protect medical resources in various communities and to make possible the medical care of large groups of industrial employees in key wartime industries. Any calls for, or offers of, assistance along this line will be gladly received by Dr. Harold A. Fletcher in San Francisco or Dr. Edward M. Pallette in Los Angeles.

Third Medical Officers Recruiting Board Established in California

In order to expedite the procurement of California's quota of Physicians and Dentists for War Service, a third Medical Officers Recruiting Board has been established in California, with headquarters in the Medico-Dental Building, 1127 11th Street, Sacramento, California. Formerly there were only two recruiting boards, one in Los Angeles, and one in San Francisco.

The North Central Board with Headquarters in Sacramento will serve thirty counties, namely:

Alpine, Amador, Butte, Calusa, Calaveras, El Dorado, Fresno, Glenn, Lassen, Madera, Mariposa, Merced, Modoc, Nevada, Mono, Placer, Plumas, Sacramento, San Benito, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba.

This board is in charge of Lt. Colonel Carlton S. Allen, M. C., senior recruiting board officer of California. Inquiries may be addressed to Colonel Allen or to Captain Irving J. Taber, Adjutant and Summary Court Officer, Telephone 3-5415.

Blood Donors Needed

Blood donors are needed at the rate of 50,000 per week for the next 12 months, Chairman Norman H. Davis, of the American Red Cross has announced. The Army and Navy have requested a new quota of 2,500,000 pints of blood within that period.

The blood collected by the Red Cross will be processed into dried plasma and serum albumin for emergency transfusions for the armed forces. The serum albumin is a recently developed blood substitute in which the Navy is especially interested because it requires less storage space than plasma.

The blood must reach a processing laboratory within 24 hours after it is drawn. For that reason, the Red Cross has had to limit donor centers to those regions near processing laboratories. Red Cross blood donor centers for the Army and Navy now exist in the following cities: New York, Philadelphia, Baltimore, Rochester, N. Y., Buffalo, Boston, Cincinnati, Cleveland, Chicago, Detroit, Pittsburgh, Indianapolis, St. Louis, Milwaukee, Los Angeles, San Francisco, and Washington, D. C.

Those who have already given blood can do so again. The average healthy man or woman can safely give blood for transfusions every three months, according to a recent report to the American Medical Association. The safe time is marked by the return to normal value of the hemoglobin, red coloring matter of the blood.—Berkeley Gazette, August 7.

C.M.A. MEMBERS IN MILITARY SERVICE**

Yuba-Sutter-Colusa County Medical Society

Members of the Yuba-Sutter-Colusa County Medical Society on Active Duty with the Army and Navy.

(Report, as of August 4, 1942. Total Number, 4.)

Name	Rank (if known)	Service (if known)
Delamere, Granville S.—Major.....		Army
Hamilton, Robert L.—Captain.....		Army
Miller, Benjamin F.—Captain.....		Army
Swift, Leon M.—Captain.....		Army

Los Angeles County Medical Association

Members of the Los Angeles County Medical Association on Active Duty with the Army and Navy.

(Although addresses are not listed, any member who wishes to communicate with any of his confreres may do so by directing the letter to the office of the Secretary of the Los Angeles County Medical Association, 1925 Wilshire Boulevard, Los Angeles.)

(Report, as of August 25, 1942. Total Number, 370.)

Name	Rank (if known)	Service (if known)
Allen, Carlton S.—Lt. Col.....		Army
Alsberge, E. Wallar—Captain.....		Army
Alsberge, Marden—1st Lieut.		Army
Alward, H. Cedric.....		Army
Andersen, Geo. Carl.....		Navy
Anderson, C. Russell—Major.....		Army
Anderson, Forrest N.—Major.....		Army
Anderson, Frank M.—1st Lieut.....		Army
Anderson, Milford X.—Captain.....		Army
Anderson, Stanley B.—Major.....		Army
Arkush, Albert S.—Lt. Comdr.....		Navy
Arnold, Ferris—Major.....		Army
Arnold, Walter F.—Lieut.....		Navy
Auerbach, Oscar—1st Lieut.....		Army
Babcock, Donald T.—Major.....		Army
Balyeat, F. S.....		Navy
Barnes, Norman J.—Lieut.....		Army
Barnum, Glenn L.....		Navy
Barshop, Nathan—Captain.....		Army
Barton, Edw. Wm., Jr.—Lieut.....		Navy

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Behrens, Herbert C.—Lieut.....	Army	Golenternek, Dan—Captain.....	Army
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Bernstein, Theodore I.—Captain.....	Army	Gordon, Gerald—1st Lieut.....	Army
Billig, H. E., Jr.—Lieut.....	Navy	Gordon, Kenneth W.—1st Lieut.....	Army
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Blatherwick, Norman—Lieut.....	Army	Grant, R. S.—Lieut.....	Army
Blood, Russell H.—Lt. Comdr.....	Navy	Greene, H. Harvey—Lieut.....	Navy
Bower, Albert G.—Lt. Comdr.....	Navy	Groskloss, H. H.—Lieut.....	Navy
Boyes, Joseph H.—Major.....	Army	Grossman, Carl M.—1st Lieut.....	Army
Bradford, Fred E.—Lieut.....	Navy	Gunther, Lewis—Lt. Comdr.....	Navy
Branch, C. H. H.—Lieut.....	Navy	Gurdin, Michael M.—Lieut.....	Navy
Brem, Thomas H.—Captain.....	Army	Hadley, R. C.—1st Lieut.....	Army
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Bryant, Ben L.—Lt. Comdr.....	Navy	Harner, C. E.—Comdr.....	Navy
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Budd, John W.—Lt. Comdr.....	Navy	Hawkins, Leland.....	Army
Budge, Edwin S., Jr.—Lieut., s.g.....	Navy	Hawley, Carl J.—1st Lieut.....	Army
Burger, Raymond A.—1st Lieut.....	Army	Henderson, Jesse L.—Lt. Comdr.....	Navy
Burke, George T.—Lieut.....	Navy	Hendricks, Coleman B.—Captain.....	Army
Burns, G. Creswell—Captain.....	Army	Henrichsen, Arthur L.—Captain.....	Army
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Butt, Edward M.—Lt. Comdr.....	Navy	Henstell, Henry H.—1st Lieut.....	Army
Cameron, Markley C.—Lt. Comdr.....	Navy	Hiatt, Nathan.....	Army
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Collins, Donald C.—Major.....	Army	Houck, George H.—Major.....	Army
Costolow, Wm. E.—Comdr.....	Navy	Huenergardt, Alfred G.—Captain.....	Army
Cozen, Lewis N.—Major.....	Army	Huff, Louis Legros—Captain.....	Army
Crane, N. F.—Captain.....	Army	Hughes, S. E., Jr.—Lt. Comdr.....	Navy
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DeLong, Everett W.—1st Lieut.....	Army	Jacob, Harry H.....	Army
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Dickmann, Richard C.—1st Lieut.....	Army	Jacobus, Willis L., Jr.—Captain.....	Army
Dodd, A. M.—Major.....	Army	Jamison, H. W.—Captain.....	Army
Donohoe, E. C.—Major.....	Army	Jenney, E. Ross—Major.....	Army
Doroshov, George D.—Captain.....	Army	Johnson, Harvey—Captain.....	Army
Downey, Thomas P.—1st Lieut.....	Army	Johnson, James B.—Captain.....	Army
Dunbar, W. Vernon—Lt. Comdr.....	Navy	Jones, Archie A.....	Navy
Duncan, John J.—Captain.....	Army	Jones, F. Harriman.....	Army
Ebers, T. M.—Lieut.....	Navy	Jones, Glen Ellis—Captain.....	Army
Eckhardt, Wymond—Captain.....	Army	Josephs, Louis—Lt. Comdr.....	Navy
Eng, Samuel Yen—1st Lieut.....	Army	Judge, W. Donald—Major.....	Army
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Ewing, John P.—Lieut.....	Navy	Kaplan, Harry E.—Lt. Comdr.....	Navy
Faier, Herman I.—Captain.....	Army	Kay, Raymond.....	—
Falconer, F. H.—Lt. Comdr.....	Navy	Keipp, James V.....	Army
Fish, Lester Warren—Major.....	Army	Kellogg, Frederick—Major.....	Army
Flynn, J. F., Jr.....	Navy	Keltz, Charles—1st Lieut.....	Army
Friedman, Lawrence J.—1st Lieut.....	Army	Kesling, Emmett F.—Captain.....	Army
Gallup, Charles A.—Lieut.....	Army	Keye, John D.—Lt. Comdr.....	Navy
Gazzaniga, D. A.....	Navy	Kibby, S. V.—Lt. Col.....	Army
Gendel, Samuel—1st Lieut.....	Army	Kiefer, Albert L.—1st Lieut.....	Army
Gernand, Henry C.—Lieut.....	Navy	King, Robert W.—Captain.....	Army
Gibson, Wm. R.—Captain.....	Army	King, Stuart D.—1st Lieut.....	Army
Globerson, Irwin—1st Lieut.....	Army	Kinyoun, F. H.—Major.....	Army

Kirchner, H. J.—Captain.....	Army	Paul, Olin—Captain.....	Army
Kiskadden, Wm. S.....	Army	Pattison, A. C.—Major.....	Army
Klausner, John T.—Captain.....	Army	Payne, Royal C.—Captain.....	Army
Klor, Samuel J.—1st Lieut.....	Army	Pentz, Clarence R.—Lt. Comdr.....	Navy
Krieger, Sherburne—Captain.....	Army	Person, Edward C.—Lieut.....	Navy
Landers, Clyde H.—Captain.....	Army	Peterfy, Richard A.....	Army
Larson, E. Eric—Lt. Comdr.....	Navy	Pierce, Wilmot F.....	—
Leake, William H.—Lt. Comdr.....	Navy	Pierose, Perry N.—1st Lieut.....	Army
Leavitt, Arthur S.—Captain.....	Army	Pohlman, David A.—Captain.....	Army
Leffingwell, F. E.—Captain.....	Army	Pohlman, Max Edward—Lieut.....	Navy
LeVan, Paul.....	Army	Popkin, Roy J.—Major.....	Army
Lewis, Charles H.—Captain.....	Army	Posner, Charles—Captain.....	Army
Lindsley, St. Claire R.—1st Lieut.....	Army	Potasz, Thomas M.—Captain.....	Army
Linne, Francis B.—Captain.....	Army	Powers, Edward S.—1st Lieut.....	Army
Lloyd, Allen S.—Lieut.....	Navy	Presnell, James F.—Major.....	Army
Lloyd, Oliver D.—Captain.....	Army	Pressman, Joel J.—Lieut.....	Navy
Lobel, Charles S.—1st Lieut.....	Army	Prigge, Edward K.—Major.....	Army
Lomas, Max I.—Captain.....	Army	Ray, Earl B.—Major.....	Army
Lovell, R. A.—Major.....	Army	Raney, A. A.—Captain.....	Army
Loy, Monroe F.—1st Lieut.....	Army	Reeder, Charles W.—Lt. Comdr.....	Navy
Lund, LeVal—Lt. Comdr.....	Navy	Redfern, Wendell M.—Captain.....	Army
Lynch, James M.—Lt. Comdr.....	Navy	Reeves, David Lander—Major.....	Army
MacKinnon, Douglas D.—Lt. Comdr.....	Navy	Reinertsen, B. R.—Lt. Comdr.....	Navy
MacMillan, Douglas W.....	Army	Reynolds, Fred'k. G.—Captain.....	Army
Magnuson, Harold J.....	Navy	Rhind, Ralph—Lieut.....	Navy
Malis, Sol.—Major.....	Army	Richardson, Gordon L.—Captain.....	Army
Mandel, Charles—Captain.....	Army	Riddell, Herman I.—Lieut.....	Army
Maner, Geo. D.—Lt. Comdr.....	Navy	Riskind, Lester A.—Lieut.....	Navy
Manning, John G.—Major.....	Army	Roberts, Gilbert J.—Lt. Comdr.....	Navy
Mapes, Russell W.—Major.....	Army	Roberts, John F.—Major.....	Army
Marco Joseph.....	Army	Roehm, E. A.....	Army
Marians, Abraham—1st Lieut.....	Army	Roen, Paul B.—Lt. Comdr.....	Navy
Mark, Bernard J.....	Army	Rogers, Maurice B.—Captain.....	Army
Marshall, James M.—Lt. Comdr.....	Navy	Rogers, Thomas J.—1st Lieut.....	Army
Martin, Harry W.....	Army	Rose, Sidney J.—1st Lieut.....	Army
Mason, J. I.—Captain.....	Army	Rosenberg, I. G.—Lieut.....	Navy
McCune, Scott S.—Major.....	Army	Rosenthal, A. M.—Lt. Comdr.....	Navy
McCuskey, Charles F.—Major.....	Army	Rosoff, Leonard—Captain.....	Army
McElhinney, P. P. B.—Lt. Comdr.....	Navy	Rosove, Leon—Lieut.....	Navy
McEvers, Albert E.—Colonel.....	Army	Ross, Rex L.—Lieut.....	Navy
McGowan, Donald O.—Captain.....	Army	Rosser, Bernard H.—1st Lieut.....	Army
McKeever, Francis.....	Army	Rothman, Phillip E.—Lt. Comdr.....	Navy
McKenna, Stephen E.—1st Lieut.....	Army	Rubenstein, Victor G.—Captain.....	Army
McKibbin, John—Captain.....	Army	Ruddock, John C.—Comdr.....	Navy
McMaster, Paul E.—Lt. Comdr.....	Navy	Ryan, Clark D.—Lt. Comdr.....	Navy
Melhorn, Kent C.....	Navy	Sacasa, Carlos F.—Captain.....	Army
Miller, Alden H.—Lieut.....	Navy	Salomon, Werner—1st Lieut.....	Army
Miller, C. Duane—Lt. Comdr.....	Navy	Sands, Robert L.—Major.....	Army
Miller, David—1st Lieut.....	Army	Saverien, Arnold E.—Comdr.....	Navy
Mitchell, William J.—Captain.....	Army	Saylin, Joseph—Colonel.....	Army
Mitchelson, Delmar S.—Captain.....	Army	Schade, Frank F.—Major.....	Army
Mooney, H. S.....	Army	Schenk, Harry Leon—Major.....	Army
Moore Oliver M.—Captain.....	Army	Schild, Emmett L.—Major.....	Army
Moore, Robert L.—Major.....	Army	Schmidt, Allen R.—Captain.....	Army
Moran, Frank A.—Captain.....	Army	Schmidt, Philipp E.—Major.....	Army
Mortensen, Wm. L.....	—	Schmoele, John M.—Comdr.....	Navy
Motchan, Louis A.....	Army	Scholtz, Julius R.—Major.....	Army
Mourer, Lyle A.—Captain.....	Army	Schroeder, Ralph L.—Captain.....	Army
Mozar, Harold—1st Lieut.....	Army	Schwartz, J. L.—Comdr.....	Navy
Mulligan, Harold R.—Lt. Comdr.....	Navy	Scitter, Paul F.....	Navy
Murray, Saunders—Captain.....	Army	Shachtman, Joseph M.—Captain.....	Army
Nador, George—1st Lieut.....	Army	Shackford, Bartlett C.—Lt. Comdr.....	Navy
Nasatir, A. Victor—Captain.....	Army	Shelton, Robert M.—1st Lieut.....	Army
Nees, Oliver R.—Comdr.....	Navy	Shear, Sidney P.—1st Lieut.....	Army
Nesburn, Henry R.....	Navy	Shuman, John Wm., Jr.—1st Lieut.....	Army
Nisbet, Thomas W.—Major.....	Army	Shuman, John Wm., Sr.—Lt. Col.....	Army
Nixon, Norman—Major.....	Army	Sicherman, Karl L.—Major.....	Army
Norwood, Jackson.....	Navy	Silver, Bernard—Lieut.....	Navy
Pahl, Blythe W.—Lieut.....	Navy	Simon, Julius—Lieut.....	Navy
Paine, Norman C.—Lt. Comdr.....	Navy	Simonds, Robert—Captain.....	Army
Palette, Edw. C.—Major.....	Army	Slaughter, Howard C.—Lt. Col.....	Army

Sloan, Ralph V.—1st Lieut.....	Army
Smallwood, W. C.....	Navy
Smedley, Robert C.....	Navy
Smith, Harold D.....	Army
Smith, Roy D.—Lieut.....	Navy
Snyder, Wm. H., Jr.—Captain.....	Army
Soll, Sydney N.—1st Lieut.....	Army
Sorenson, Edward J.—1st Lieut.....	Army
Southgate, Paul.....	Navy
Spalding, W. Cullen—Major.....	Army
Sperling, Samuel J.—Captain.....	Army
Stanton, E. H.....	Army
Staub, John G., Jr.....	Army
Steckel, Morris Leo—Captain.....	Army
Steele, Edson H.....	Navy
Stehly, Charles C.—1st Lieut.....	Army
Stern, Robert Leo—1st Lieut.....	Army
Stevens, Joseph B.—Lt. Comdr.....	Navy
Stewart, Charles M.—Captain.....	Army
Stilwell, Leland E.....	Army
Stocker, Howard O.—1st Lieut.....	Army
Stout, Gurn—Lt. Comdr.....	Navy
Sullivan, Daniel F., Jr.—Lieut.....	Navy
Syman, Leo W.—Captain.....	Army
Szukalski, Joseph P.—Major.....	Army
Taber, Kenneth W.—Captain.....	Army
Taylor, Charles M.—Captain.....	Army
Thorner, M. C.—1st Lieut.....	Army
Tidd, Charles W.....	Navy
Toma, John J.—1st Lieut.....	Army
Townsend, Kenneth.....	Army
Turner, Ewing L.—Captain.....	Army
Tyroler, Frederic N.—Lieut.....	Navy
Tysdale, Richard V.—Lieut.....	Army
Vaughn, John.....	Navy
Vidgoff, I. Jack—Captain.....	Army
Walker, J. E.—Lt. Comdr.....	Navy
Waller, Lorenz M.—Major.....	Army
Ward, Henry Charles—1st Lieut.....	Army
Ware, E. Richmond—Lt. Col.....	Army
Watson, L. C.—Lieut.....	Army
Weber, Henry M.—Comdr.....	Navy
Webster, Geo. E.....	Army
Weinberg, Samuel J.—Captain.....	Army
Weinberg, Sydney L.—Major.....	Army
Westerhout, F. C.—Captain.....	Army
Wexler, Manuel R.—Captain.....	Army
White, Carroll W.—1st Lieut.....	Army
Whitlow, Joseph Edwin—Major.....	Army
Whittaker, Thomas W.—Captain.....	Army
Wilkinson, Allan B.....	—
Wilson, Clinton—Major.....	Army
Wilson, Warren A.—1st Lieut.....	Army
Wineland, A. J.....	Navy
Wirth, Robert G.—1st Lieut.....	Army
Wolfson, Samuel A.—1st Lieut.....	Army
Wright, John.....	Navy
Wvers, Robert E.....	Army
Zide, Harry Arthur—Captain.....	Army
Zombro, Frederick B.—Captain.....	Army

Dr. Morton R. Gibbons Tells OCD Rules

Emergency medical services in San Mateo County civilian defense today faced the necessity of reorganization of personnel and procedure to conform to Office of Civilian Defense regulations, laid down Tuesday night in Burlingame by Dr. Morton R. Gibbons, deputy state chief of emergency medical service.

Addressing assembled local emergency medical chiefs and their deputies at county civil defense headquarters, Dr. Gibbons pointed out that the national plan calls for dispatching doctors to the scene of incidents as soon as

possible. Heretofore first aid and ambulance teams have been dispatched by control centers to bring casualties to doctors at hospitals or casualty stations.

Hospital Dispatching

Dr. Gibbons recommended that squads of doctors and nurses be organized and dispatched from hospitals.

"Doctors must take charge," he emphasized, citing heavy fatalities in England and Spain resulting from lack of professional aid at the scene of casualties, or in casualty stations where inadequate equipment and personnel made adequate examination and treatment impossible.

First aid teams as such, except in factories, will henceforth be known as "stretcher bearers" to conform to OCD terminology.

Casualty stations will not be manned until after an incident has occurred.

Control Room Dispatcher

Emergency medical service chiefs, sitting at the control centers, will dispatch squads from hospitals. Squads comprise from two to four doctors, nurses, auxiliaries, equipped to man a casualty station or to set up a first aid post at the scene of an incident.

Ambulances will be dispatched by the transportation officer or Red Cross officer on the control board, as the case may be.

These and other details were explained to the emergency medical service director. . . . —Redwood City Gazette, August 7.

Los Angeles Civilian Defense Facilities

Los Angeles, July 29.—(AP.)—California steel mills and foundries may have to close down unless the public can provide 100,000 tons of scrap metal every month.

James Mussatti, general manager of the California State Chamber of Commerce, gave that information on the war metals crisis to the state council of defense at its conference yesterday.

Facilities Ready

Major Charles F. Sebastian of the United States Public Health Service told the conference that in the event of air raids Southern California's 4,000,000 population will be served by an available 17,107 regular hospital beds, 6,357 extra beds and 4,891 cots, 8,396 stretchers, 2,228 physicians, 4,454 graduate nurses, 332 commercial ambulances, 1,287 volunteer and fully equipped ambulances, and 1,320 additional emergency medical vehicles.

He said there are 446 casualty stations.—Sacramento Bee, July 29.

Army and Navy Will Need Thousands of Medical Men

A wartime census of its members by the American Medical Association reveals that the United States today has more than 176,000 physicians, an increase of 64,000 since 1930. Of this number, approximately 81,000 are under 45 years of age. Fully two-thirds of these, under present Army and Navy plans, will be called into the armed services to build up understaffed medical corps. Since the country is going to find itself in the near future without the services of some 50,000 to 60,000 physicians now engaged in civilian practice, the public will have to take upon itself some of the duties of safeguarding the nation's health. A nation of healthy workers is a priceless asset at any time, but never more so than in a war period. . . .

Of the 152,923 physicians in private practice in the United States in July, 1942, there were 37,753 under 35 years of age.—Martinez Gazette, July 31.

Medical Schools Setting Record

Chicago, Aug. 13.—(AP.)—The American Medical Association estimated today that approved medical schools, operating under wartime accelerated programs, will graduate a record total of 21,029 students during the next three years.

The number is "5,082 more than would have graduated without the adoption of the accelerated programs," the A.M.A. Council on Medical Education and Hospitals reported.

"Never before in the history of this country have as many as 21,000 physicians been graduated from its medical colleges within a three-year period."

The A.M.A. Journal, estimating that 3,460 physicians died in the United States during 1941, said the 21,029 graduates would provide more than two new physicians for every death.—Los Angeles *Examiner*, August 14.

A War to Save Lives

Rear Admiral Ross T. McIntire, personal physician to the President and Surgeon General of the U. S. Navy, arrived in San Francisco yesterday on an inspection tour of Pacific Coast naval medical installations.

The Navy, he said, is waging a war at home in its medical laboratories—a war against the limits of medical science in order to keep its seagoing Samaritans "at least one jump ahead of the game."

"We've got to keep ahead of our problems in the field," he declared.

This involves endless laboratory research, the evolution of new medical techniques and the quick transmission of new knowledge gained to the field of operations.

While doctors aboard America's fighting ships are saving lives, naval doctors at home are exploring the qualities and uses of sulfa drugs, blood substitutes, treatment of chest wounds, abdominal wounds, means of increasing pilots' stamina and a myriad of other life saving elements.

Fatality Decline

"Wounds of a chest and abdominal character which were extremely serious during the first World War today result in less than 10 per cent fatality, due to medical advancement," the admiral said.

The Navy consistently is finding new uses for the sulfa drugs, Admiral McIntire said, and also is finding "ways and means" of increasing the stamina of its air pilots.

Every naval unit numbering 150 men or more has its medical officer, he reported. Certain types of units whose operation involve a higher than average degree of danger, are assigned additional medical personnel.

"If a man is wounded in action today, even if he is wounded seriously, he has every chance to live."

The Navy's great floating hospitals today are "scattered all over the world." All have been doing yeoman service when called upon.

While here Admiral McIntire will inspect the Mare Island, Treasure Island and Oak Knoll hospitals. "You have here, in your own midst, at Oak Knoll, several wounded men who received their injuries at Midway," he declared.

Chief problem facing Navy medical officers today is the transportation of medical supplies across the continent and into the Pacific theater "so that they will be at their destination before they are needed," Admiral McIntire said. "This problem is being solved," he added.

Syphilis constitutes a minor problem to Naval medics, the Admiral declared, only 5.2 per thousand men being affected. "We have reduced the Naval syphilis rate 7 per cent from its fiscal 1941 figure," he said.

Today's Naval syphilis rate is the lowest it has been

in the last 40 years, according to a recent review of medical records, he reported.

President Roosevelt's health is "better than it has been during the past three years," the Admiral said.—San Francisco *Chronicle*, August 21.

Suggestions to the Public. By the National Committee on Participation of Medical Profession in the War Effort

The War Participation Committee of the American Medical Association (including Drs. Walter F. Donaldson, Pittsburgh, Chairman; Edward R. Cuniffe, New York; Clyde L. Cummer, Cleveland; John H. O'Shea, Spokane, Wash., and William R. Molony, Sr., Los Angeles, and as ex officio members the President, the President-Elect, the Chairman of the Board of Trustees, the Secretary and the Editor of the Journal of the American Medical Association), has given consideration to the problem of the supply of physicians for the armed forces, for industry, and for the need of our civilian communities.

While there does not seem to be an immediate shortage of physicians for the nation as a whole, the voluntary departure of some physicians from certain areas has created in those areas a special problem. With the armed forces rapidly expanding, the number of areas in which the available physicians will be at a minimum is likely to increase.

In order to aid the best and most efficient possible utilization of available medical services, the War Participation Committee of the American Medical Association makes the following suggestions:

1. Call the doctor to your home only when necessary. Go to his office when you can.
2. Help the doctor to plan proper use of his time by calling him before nine o'clock in the morning whenever possible.
3. Have an examination at the first sign of sickness. This helps to prevent long and serious illnesses.
4. Some conditions are best treated in the hospital. Doctors can see more patients in the hospital in the same amount of time than elsewhere. Coöperate by providing in advance against the cost of hospitalization. Go to the hospital when the doctor recommends it.
5. Have yourself immunized against smallpox and lockjaw. Make certain that all children are vaccinated against smallpox and diphtheria. When outbreaks of diphtheria or other infections threaten, coöperate with health officers and doctors in prevention.
6. Avoid overeating, overdrinking, overworking and overexercising. Get a good diet. Follow the rules of personal hygiene.
7. Women should take first aid courses and nurse's aid training courses of the Red Cross. This will help to relieve the burden on the physician and nurses in the hospital and in the home.
8. Every doctor not already in the armed forces is probably doing extra work in industry, public health and in his private practice. Help him to conserve his health by avoiding any unnecessary responsibilities for him.

Military Clippings—Some news items of a military nature from the daily press follow:

War Requires Blood

There is no patriotic San Franciscan who would not gladly shed his blood on the field of battle if he might thereby enhance his country's prospects of victory.

And so there should be none who will fail to heed the appeal for blood donations that will be made throughout this week by the city's three blood procuring agencies—the Red Cross Blood Procurement Center, the Irwin

Memorial Blood Bank and the San Francisco Hospital Blood Bank.

For blood so given is as direct and valuable a contribution to the war as that spilled in the conflict.

In one sense it is more valuable. For we at home give our blood for the constructive purpose of restoring our wounded fighters to health and life.

Blood gathered by the agencies will be used, for the most part, in the making of plasma which will be sent to our military hospitals and ships all over the world, to be used in lifegiving transfusions for our wounded.

Certainly no finer nor more patriotic contribution to the war effort is conceivable. And surely no thrill could be greater than the knowledge that some son has been restored to his mother, or some husband to his wife, because our blood has healed him and restored his strength.

The development of the plasma technique, which enables our doctors to save many boys who surely would have died in earlier wars, is one of the few scientific achievements operating to relieve the stark horror of this conflict.

There should be, there MUST be, a great response to this vital appeal throughout this "Blood Donor Week." As more and more boys fall in battle, the need for plasma grows, and it will continue to grow until the war is won. So let every healthy person call GRaystone 9373 and make an appointment for a blood donation.—San Francisco *Call-Bulletin*, July 27.

Blood Donor Week

A stream of blood and blood plasma to flow from San Francisco to the far-flung battlefields where American boys are shedding their own blood for preservation of the nation is the objective of this Blood Donor Week.

People of this city, living amidst peaceful surroundings, are asked to donate their blood to replace the blood our soldiers, sailors and marines are losing in conflict.

Those who have not yet made this life-giving contribution are urged to visit one of the blood banks during the week, and those who previously have generously shared their blood with the country's defenders are asked to give again.

The blood banks are the Red Cross Blood Procurement Center, 2415 Jones St., the Irwin Memorial Blood Bank, and the San Francisco Hospital Blood Bank. The first two send blood and plasma to foreign fields, the latter supplies the local hospitals.

No hardship or physical injury is suffered by donors. It is, indeed, not an unpleasant experience. Compared with the sacrifice our armed forces are making it should be considered a high privilege.—San Francisco *News*, July 29.

Vaccine Use Given Support

Chicago, July 28.—(UP.)—The Journal of the American Medical Association said in an editorial today that the development of jaundice among army personnel apparently from the use of vaccine against yellow fever was far less serious than an epidemic of the fever would be among soldiers fighting in tropical areas.

"There is every reason to believe that vaccination against yellow fever is warranted," the editorial said, "and that the occurrence of 62 deaths and some 28,000 cases of jaundice associated with the vaccination of millions of men is far less serious than would be an epidemic of virulent yellow fever among soldiers sent to the tropical areas in which our army is now engaging the enemy."

The editorial said the vaccine had been tested in "hundreds of thousands of cases" and had been adequate.—Oakland *Post-Enquirer*, July 28.

Dental Students Enroll for Armed Services

San Francisco, Aug. 25.—Practically the entire student body at the University of California College of Dentistry has now enlisted in the Reserve Corps of the Army and Navy, Dean Willard C. Fleming announced today.

The total enrollment at the College is now 200, said Dean Fleming. The students who have enlisted will remain on inactive service until graduation when they will be called to active duty. Special instruction is being given the enlisted students to prepare them for duty in the Army and Navy. . . .—U. C. *Bulletin*.

British Limits M. D. Supplies New Rations to Go Into Effect

British physicians and nurses are restricted to a maximum of three pairs of rubber gloves apiece at a time, under the new rationing policy of the British Ministry of Health. The Japanese occupation of Malaya has also

made it necessary to restrict rubber supplies to hospitals and clinics, according to a report from London published in the Journal of the American Medical Association.

Medical use of alcohol is also restricted. The Minister of Health has issued an alternative list of spirits and tinctures to be used, which have substantially the same effect although they contain less alcohol.—San Francisco *News*, August 7.

Deferments Withdrawn

Sacramento, Aug. 25.—(INS.)—Withdrawal of men originally deferred for occupational reasons was ordered today by Lieutenant Colonel K. H. Leitch, state director of selective service.

He declared these men originally were "loaned" to industry but that now they were needed to meet the increasingly heavy demands of the armed forces.

Occupational deferments to men engaged in agriculture and other seasonal work where replacements are not available will not be disturbed at this time.

Up to Boards

Leitch told boards to deny applications for occupational deferments in cases where only a short replacement training period is required and where the registrant does not have a background of the kind of work in which he is engaged or related work.

In considering applications for extensions of occupational deferments the boards were told not to grant an extension unless the employer convinces the board that a reasonable but unsuccessful effort has been made to secure and train a replacement.

The boards were directed not to release class 1-B registrants for the purpose of enlisting. This rule was laid down to prevent necessary employes from leaving war and essential industries en masse, crippling production.

Aid War Work

The withdrawal of these registrants will be effected in an orderly manner.

Leitch said in the past selective service has protected vital industries and that so far as possible this will be done in the future.

Married Men in 3-A Class Face Call by Christmas

Hershey Indicates Draft for Navy Planned

Chicago, Aug. 21.—(INS.)—Married men now classed in 3-A will face a draft call by Christmas, Maj. Gen. Lewis B. Hershey, national director of Selective Service, warned today.

General Hershey added that men with wives and children, would be the last to be called, and that drafting of men for the Navy, Marine Corps and the Coast Guard is "coming into the picture."

The general, addressing the National Institute for Commercial and Trade Association executives at Northwestern University, added that "this drafting of men for the other services has not been arranged as yet, but is in the offing."

"Industry will have to begin immediately the giving up of men who are suitable for the armed forces," the general said, continuing:

"Vital war industries have been notified they too must give up skilled men if they come under the classification of married men with wives only and unmarried men with one dependent, such as mother or sister. Their places must be filled with older men, the physically unfit for service, or women."

General Hershey said draft boards have begun the reclassification of deferred men because they are skilled workers in war plants.

"The drafting of married men will take place in late October or early November, certainly by Christmas," the draft chief declared.

Near End of Rope

"Even one-armed or one-legged men will have to run machines in factories, if necessary, as we fill out the Army with able-bodied men now in plants."

"Draft boards now are sorting 3-A men to get 1-A men to fill quotas, and the boards are pretty near the end of the rope."

General Hershey reaffirmed the order in which 3-A men will be drafted:

- 1.—Single men with secondary dependents, such as aged or crippled relatives;
- 2.—Married men whose wives are employed;
- 3.—Men with dependent wives only;
- 4.—Men with dependent wives and children.—San Francisco *Examiner*, August 21.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Basic Science Act—Proposition No. 3

Now is the time for all members of the medical profession to start campaigning for the passage of the Basic Science Act, Proposition No. 3 on the state ballot for November 3. Only about six weeks remain before Proposition No. 3 comes before the voters of California; every member of the profession must do all in his power in that time to gain a "YES" vote for the Basic Science Act.

Our biggest opponent at this time is public apathy. Voters are more interested in the war and its effects upon themselves and their friends and families than they are in political measures. The only way to fight this opponent is to talk to your friends, patients, acquaintances, and urge them to vote "YES" on No. 3. Talk about No. 3 on every occasion. Identify yourself and your profession with it.

There is no need of going into long discussions with people on the merits of the Basic Science Act. Merely explain to your friends that it is an educational measure to raise standards. Its educational nature is attested to by the fact that the official arguments in favor of No. 3, which will accompany the Voters' Manual mailed to all electors by the Secretary of State, are signed by three of the leading educators in California. The signers of these arguments are Dr. Ray Lyman Wilbur, Chancellor of Stanford University; Rufus B. von KleinSmid, President of the University of Southern California, and Tully C. Knoles, President of the College of the Pacific.

The Basic Science Act does not put any present practitioners of any of the healing-arts out of business. It does not limit the patient's choice of the healer or type of healer he selects. It merely guarantees to the patient that future licentiates in any of the healing-arts shall first obtain an elementary training in the basic sciences which underlie the healing-art. The examinations to test this knowledge are to be given by a non-sectarian board of examiners to applicants who shall be known to the examiners only by number. Every safeguard has been arranged to provide an impartial, completely fair, examination. The act will add nothing to the taxpayer's burden; the Basic Science Examining Board will be completely self-supporting.

Proposition No. 3 will not "legislate anyone out of existence," as some of its professed opponents are likely to claim. Its one effect will be to make better physicians, better dentists, better osteopaths and better chiropractors.

Here are a few suggestions for each physician who wants to help in this campaign:

1. Enclose the small slips already sent you by the Public Health League of California in all mailings from your office.
2. Place these slips (and the small folders which you will soon receive) within reach of your patients in your waiting room.
3. Speak favorably on Proposition No. 3 on every occasion possible—in your home, in homes of friends, at service club meetings, lodge or club meetings, in street conversations, in your office, etc. Urge a "YES" vote.
4. Notify the Public Health League of California (244 Kearny St., San Francisco, or Chamber of Commerce Building, Los Angeles) of any openings you can

discover for a speaker before groups.

5. Notify the Public Health League or the secretary of your county medical society of your availability as a speaker. Full instructions will be furnished you.

6. Ask for the endorsement of all groups for Proposition No. 3. These endorsements are particularly valuable and obtainable if you get in and ask for them.

Remember, Proposition No. 3 is a non-partisan educational measure. Its success at the polls in November will rest largely with the members of the medical and allied professions and the amount of work they will do to promote it. There is no large amount of money available for advertising and other forms of campaign propaganda. There is only the collective effort of professional men and their friends. THAT'S WHERE YOU COME IN.

Affirmative Argument on Proposition No. 3: Basic Science Initiative

The object of proposition No. 3, the Basic Science Initiative, is to provide a means of insuring that all candidates seeking the right to care for sick and injured people in California shall first possess a reasonable knowledge of the sciences fundamental to the healing-art.

When Proposition No. 3 becomes law, all applicants for a license to practice the healing-art must first pass examinations in five basic sciences—Anatomy, Physiology, Biochemistry, Bacteriology and Pathology. This examination is for the purpose of making a reasonable test as to whether the person so examined has some knowledge of the elementary principles of the basic sciences, which underlie the healing-art.

The Basic Science examinations will be conducted by educators. The Board of Examiners will consist of five persons appointed by the Governor. All appointees shall be selected because of their knowledge of the Basic Sciences. Each appointee shall be and remain an associate professor or full professor in one or more of the Basic Sciences at a university or college in this state, of equal or higher rank than a state college, or an active full time member of the faculty in one or more of the Basic Sciences in a state college.

Only one member of the Board may be appointed from any one university, state college or other institution.

NO MEMBER OF THE BOARD SHALL BE ACTIVELY ENGAGED IN THE PRACTICE OF THE HEALING-ART OR ANY BRANCH THEREOF.

The Board of Examiners in the Basic Sciences will be self-sustaining. There will be no cost to the taxpayers of California.

Present practitioners holding medical, dental, osteopathic or chiropractic licenses are exempt from the provisions of Proposition No. 3. Other exemptions include pharmacists, nurses, dental hygienists, optometrists, barbers, cosmetologists. Persons who treat the sick by prayer in practicing the religion of any well-recognized religious sect or organization are specifically exempt.

Sixteen states and the District of Columbia now have Basic Science Acts, to insure their sick and injured citizens of treatment by healers who have an elementary knowledge of the fundamental sciences relating to the human body. California is the only Pacific coast state that does not now have a Basic Science Act.

We wish particularly to emphasize the fact that the Basic Science Act will in no way affect the systems of healing now legally recognized in California. None of the rights or privileges of persons now legally engaged in practice will be disturbed. The people of California will continue to be free to select any legally licensed healer or system of healing. They will have the assurance, however, that the State of California guarantees that future licensees of the healing-arts have an elemen-

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

tary knowledge of anatomy, physiology, biochemistry, bacteriology and pathology. Every voter should want this protection for himself and his loved ones in case of illness or injury.

Vote "YES" on Proposition No. 3 and raise California's basic educational requirements in the healing-arts to the level of other progressive states.

(Signed)

DR. RAY LYMAN WILBUR,
Chancellor, Stanford University.
DR. RUFUS B. VON KLEINSMID,
President, University of Southern California.
DR. TULLY C. KNOLES,
President, College of the Pacific.

Eighteen Measures on November Ballot

There will be 18 propositions on which will if passed involve changes the ballot at the November election in the state government, including complete reorganization of legislative and budget methods, establishment of a new authority to regulate practitioners of material healing systems, setting up of a new Forestry board, and controversial labor legislation.

Fourteen of the propositions are proposed amendments to the State Constitution which have passed the legislature. Two measures are the outcome of full initiatives. One is an initiative which was routed through the legislature with only half the number of signatures normally required. One proposition is on the ballot by referendum.

1 1 1

Proposition 3, establishing a "basic science board" of five members to regulate and control members of material systems of healing in an initiative measure sponsored by the California Medical Association, the California State Dental Association, the Southern California State Dental Association, and the Public Health League of California.

Representing 10 years' exploratory work by the organized physicians, surgeons, and dentists of the state, Proposition 3 is intended to set a minimum standard of training for any applicant whose profession calls for diagnosing, adjusting, palliating, correcting, operating, or prescribing for anyone claiming any sort of disease.

Members of any well-recognized religion who treat the sick by prayers are exempted from the requirements of the "basic science" proposal because they do not diagnose sickness nor prescribe physical correctives. Adherents of Christian Science are included in this group.

1 1 1

One of the most important measures on the ballot is Proposition No. 2, which provides for annual meetings of the State Legislature and annual budgets by state departments. If passed, this measure will do away with California's biennial system of legislative government and budgets. . . .

Most controversial issue on the ballot is Proposition No. 1, a referendum, to prohibit secondary boycotts or "hot cargo" by labor unions. . . .

An initiative measure to repeal the state income tax, Proposition No. 4, reaches the voters after they have been informed that for the first time in many years the state government is out of debt and has a surplus. . . .

Proposition 5, an enactment of the legislature, provides \$200 a month salaries for legislators. This doubles the amount legislators now earn. Under the present system, a legislator is paid \$12 a day. If the session meets 100 days, he earns \$1200. If it meets more than 100 days, he is only paid for 100. If it meets less than 100 days, he is paid only for the time served. In years the legis-

lature is not in session, a member is paid \$100 a month. This amounts to a maximum of \$2400 in two years.

Other propositions on the November ballot follow:

Proposition 6 sets up State Board of Forestry with seven members named by the governor with consent of senate; provides civil service exemption for State Forester.

Proposition 7 provides a procedure to tax insurance companies and has the support and endorsement of the companies.

Proposition 8 restricts use of fish and game funds to expenditures for fish and game conservation and enforcement.

Proposition 9 empowers legislature to diminish or increase salaries of the Superintendent of Public Instruction, State Treasurer, State Controller, and Secretary of State. At present the legislature has power to diminish these salaries but not to increase them.

Proposition 10 (an initiative measure by way of the legislature requiring only half the usual initiative signatures) provides for reorganizing building and loan associations.

Proposition 11 enables legislature to amend Boxing and Wrestling Initiative Act; permits championship boxing bouts of 15 instead of 12 rounds as at present.

Proposition 12 enables school districts, fifth and sixth-class cities, to hold stock in mutual water companies. This will permit small districts to obtain water on the same basis as large municipalities.

Proposition 13 provides additional Board of Equalization seat, eliminating controller.

Proposition 14 sets interest rate on court judgments at 5 per cent a year; interest rate on loan or forbearance of money, goods, or things in action, or accounts after demand, at 7 per cent a year, but permits parties involved to contract in writing on the interest rate which must not exceed 10 per cent.

Proposition 15 provides for transferring cases between State Supreme Court and District Courts of Appeal.

Proposition 16 establishes procedure for judicial review of decisions by administrative officers.

Proposition 17 makes State Treasurer trustee of certain money.

Proposition 18 makes State Controller a member of the State Reapportionment Commission in place of a surveyor general whose position was abolished some time ago. This commission goes into action only if the state legislature fails to move on reapportionment.—Victorville *News-Herald*, July 31.

COMMITTEE ON MEDICAL ECONOMICS

(COPY)

Statement of the
California Medical Association
for the
Office Wage Board
of the

Division of Industrial Welfare, State of California*

The California Medical Association, a voluntary mem-

* This statement by the California Medical Association has been prepared on the basis of sample surveys and of general knowledge possessed by the officers of the Association through knowledge of conditions prevalent in the 7,000 professional offices of its members throughout the State of California. The figures on out-patient visits in ten California hospitals have been secured from the August 15, 1942, issue (Educational Number) of the *Journal of the American Medical Association*. (See also, on pages 209 and 223.)

bership organization numbering close to 7,000 licensed doctors of medicine domiciled in California, wishes to present to the Office Wage Board a few pertinent facts affecting the medical profession for consideration in the adoption of any wage and hour order the Board may see fit to make.

1. Number of Employees:

It is estimated that there are 10,000 licensed, practicing doctors of medicine in California and that these employ approximately 15,000 female employees. The employees are trained either as secretarial workers or as nurses, physiotherapists, technicians or other assistants to the doctor of medicine in his professional work.

2. Existing Hours and Wages:

At the present time the office employees of doctors of medicine throughout California are employed for hours considerably shorter and wages considerably higher than the existing standards adopted by the Division of Industrial Welfare. There may be a few exceptions to this general rule, as follows:

(a) Employees of clinical pathological offices may be called upon to work additional hours in some instances where procedures in process cannot be interrupted. (Development of cultures, etc.)

(b) Employees of doctors of medicine in general or specialized practice may be called upon for extra hours where the health of the community may require the doctor to put in extra office hours or where gratis physical examinations made by the doctor on Selective Service registrants require him to maintain extra office hours. This extra-hour work of M. D.'s and their office nurses is bound to increase for the duration of the war because of the transfer to the armed forces of many doctors and nurses. Training of new nurses and technicians is not possible in time to alleviate the problem.

(c) Employees may be called upon to work extra hours in the event of epidemics or other community health needs of critical nature, where the doctor is called upon for additional time in his regular office hours. This situation may now be approaching a critical stage because of the number of doctors of medicine who have been called into the armed forces.

3. Nature of Employment in Medical Offices:

Female employees in the large majority of offices of doctors of medicine report for work at about 10 a.m., have one hour for lunch and work until about 6 p.m.; on Saturdays, many such employees are not required to perform any work and in those cases where they do work on Saturdays they are generally employed for only a three-hour or four-hour period.

In most medical offices there are few employees; the doctor of medicine generally employs only one assistant, who handles his clerical and bookkeeping work, acts as receptionist and office assistant and does such general duties as may be required. In larger medical offices, where two or more doctors employ office employees in common, there may be an additional office nurse, or a laboratory technician, or a bookkeeper, or one or more of each class of employee. It is reliably estimated that the doctor of medicine employs an average of one and one-half office assistants of all kinds.

The duties of female office employees in medical offices are regulated by the demands of patients on the time of the doctor. In times of epidemics, during winter months when respiratory diseases run at a high rate, and at all times when unusual demands are made on the doctor's time, it may be necessary to require additional working hours of the office assistants; under normal circumstances, these assistants may count upon a relatively short working week and relatively generous wages.

4. Nature of the Doctor's Duties:

It is a well-recognized fact that the doctor of medicine is on duty for 24 hours each day, seven days each week. He responds to calls at all hours of the day and night, maintains regular office hours, sets aside regular hours for visiting patients in hospitals and, in many cases, devotes a set number of hours weekly to the teaching of medical students or the attendance on patients in the free clinics of public and private hospitals. Ten hospitals in California handled 102,990 visits from out-patient surgical patients alone in the year 1941; this example indicates the large amount of time donated to this type of service by doctors of medicine. Considering all branches of medicine and all hospitals in California which render gratis out-patient service, the hours donated by doctors of medicine run into the hundreds of thousands and the monetary value of these gratis services into the millions of dollars.

5. Nature of the Doctor's Responsibilities:

The doctor of medicine maintains an inviolable confidential relationship with his patients. He is ethically and legally responsible for the maintenance of this relationship; *he is also legally and ethically liable for the maintenance of this relationship by his office employees.* This means that his office assistants must be chosen with due regard for their assumption of this responsibility and that he is not able to hire office assistants in the general labor market and to accept the services of any applicant offered. One disclosure of a patient's ailment may ruin the doctor both professionally and financially and seriously hurt the patient.

In turn, this means that the office assistants of doctors of medicine cannot be replaced on a moment's notice. The working situation in a doctor's office is not analogous to that in a business office, where additional clerical employees may be added with a lesser degree of discrimination.

6. Requests and Recommendations:

The doctors of medicine of California make no plea for the establishment of a Wage Order by this Board which will set a certain number of hours of maximum employment or a certain minimum weekly wage standard. They do, however, request the Board to take into consideration in its findings the facts recited above and to make due provision for these facts in whatever Wage Order may be forthcoming from the Board.

Specifically, the doctors of medicine petition the Wage Board to provide, in any order issued, for sufficient flexibility as to hours of employment to permit the doctors of medicine of California to maintain their physician-patient confidential relationships and to permit the working of additional hours over a weekly maximum if public health conditions so demand. If the Board sees fit to require that extra hours over a set weekly maximum shall be compensated for by the granting of a like number of hours of leisure in a later period, the medical profession would gladly assent to such an order.

Doctors of medicine are dealing with human life and health. The daily demands upon the doctors do not take into consideration the matter of hours. When epidemics or other health emergencies arise, the doctor of medicine becomes, in effect, a public health officer, upon whom may depend the health of an entire community. Under such circumstances it is patently unfair to demand that his office assistants must leave the office at the stroke of a clock, no matter how many patients may be awaiting the doctor's ministrations. If such demands are made, doctors of medicine will find themselves unable to secure additional assistants capable of maintaining the necessary confidential relationships with patients and of carrying

out the various duties of regular assistants. It should be borne in mind that, except for full time receptionists and bookkeepers in large urban offices, women employed by physicians are professional workers (e. g.—trained nurses and technicians) whose duties are an integral part of the physician's own duties. In this respect they are not comparable to employees in trades and businesses.

Forced Hospital Insurance Termed Inimical to U. S. Way

New York, July 18.—The plan of a compulsory hospital insurance tax urged by the Social Security Board would commit the United States Government to a "perfectly gigantic experiment in health administration which is entirely foreign to our democratic way of life," according to Dr. Chas. Gordon Heyd, former President of the American Medical Association.

Dr. Heyd presented a summary of drawbacks which he attributed to the proposed tax at a meeting of the Public Health Committee of the New York Academy of Medicine.

A pay-roll tax of 1 per cent—one half of 1 per cent on the employer and one half of 1 per cent on the employee—has been considered by the Social Security Board, and legislation to this end may be introduced later this year.

The tax would apply to the 40,000,000 workers now covered by the Social Security system of old age and survivors' insurance, and to any new groups of workers who might later be legislated into the system.

Payments to Insured

Out of the receipts of the tax a payment of \$3 a day or some such sum would be made by the Government. The money would be paid to the insured person, who would be expected to pay the hospital.

In addition to the insured, hospitalization would be offered to their dependents, retired workers who had been insured and their dependents, and to survivors of the insured, Arthur J. Altmeyer, Chairman of the Social Security Board, has indicated.

Much opposition to the project has arisen within the medical profession. Dr. Heyd listed objections in part as follows:

Knowledge that the patient would get \$3 a day if sick might cause a person to take advantage of the plan and malingering.

The hundreds of millions of dollars in taxes which would accrue annually would, if properly spent, provide much more than contemplated in the proposal.

Political administration would result in the diversion of a substantial portion of the money to other ends.

Naming these as some of the non-professional disadvantages, Dr. Heyd then reviewed professional demerits as including:

There is no provision in the plan that the hospital or the doctor should get the \$3 which is paid to the patient by the Government.

Assuming that the patient will turn over the \$3 to the hospital, this amount would still not cover the cost of adequate service in the great majority of hospitals in the country. Yet, if the hospital attempted to charge the difference to the patient, it would be apt to encounter difficulties due to the feeling by the patient that if the Government considered \$3 a day for hospital care sufficient, it was no doubt enough.

Disastrous Subsidies

Such a situation would leave it to the hospitals to make up the deficits, and if the Government attempted to make subsidies to the hospitals covering the difference between the actual cost and the \$3 they received, the ultimate effect on the voluntary hospitals would be disastrous. The

plan would literally kill the voluntary hospital system, and research and initiative.

If the voluntary hospital system was disrupted, there would be no standard for the governmental hospitals, for these latter hospitals have been using the voluntary hospitals as a basis of comparison.

Assuming that the plan would provide a fair and honest medical hospital insurance scheme, who would pay for the medical services? The difficulties associated with the remuneration of the staff would be apt to result in deterioration of the quality of medical service.

Medical education would be disrupted, and the medical schools would eventually require a subsidy by the Government. This would mean that proper selection of medical students would be done away with.—*Christian Science Monitor*, July 20.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Institutes on Wartime Industrial Health

San Francisco—August 18

Crockett—August 19

Oakland—August 21

San Diego—August 25

Inglewood—August 26

Glendale—August 27

Huntington Park—August 28

SPONSORED BY:

California State Department of Public Health

California Medical Association:

Committee on Postgraduate Activities and Committee on Industrial Practice.

Western Association of Industrial Physicians and Surgeons:

FOR:

The Practicing Physician, the Industrial Physician, the Industrial Manager.

Announcements concerning the "Institutes on Wartime Industrial Health" were given in the Committee on Postgraduate Activities' department of the last two issues of the OFFICIAL JOURNAL (in July issue, on page 101; in August number, on page 150). The reports below give additional information.

The committees in charge were pleased and encouraged by the attendance and interest shown in the seven cities visited. Plans are in the making for the continuation of the Institutes. The programs will be amplified and other cities selected for the next series of Institutes, which it is hoped to present before January next. Officers and members of local medical societies who may be interested are invited to forward their requests or suggestions to the C. M. A. Committee on Postgraduate Activities, 450 Sutter, San Francisco.

* * *

54-Hour Job Limit Advised by Doctor

War Workers' Health Theme of Experts Meeting Here

"We must not increase the hours of industrial labor beyond workers' physiological limits!" declared Dr. Carey P. McCord, Chryslor Corporation medical adviser, today. McCord was scheduled to be a principal speaker at the Institute on Wartime Health at the Clift Hotel this afternoon and evening.

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Thinks 48 Best

"At present, a 48-hour week is as much as any worker should put in," he explained. "If a real need arises, that may have to be increased to 54 hours, but beyond 54 hours a worker's capacity is exhausted and little can be accomplished by added hours of work."

Other institute speakers scheduled are Dr. Robert T. Legge, J. J. Bloomfield, Dr. H. T. Castberg, C. H. Fry and Fred R. Ingram.

First of Seven

Sponsored by the County Medical Society, the Institute is the first of seven such meetings to be held in California cities under the auspices of the California Medical Society, the Western Association of Industrial Physicians and Surgeons and the State Department of Public Health.

This afternoon and evening, San Francisco doctors, safety engineers, industrial nurses and management representatives are to study many phases of the health protection of war workers.—San Francisco *Call-Bulletin*, August 18.

* * *

Doctors Warn on War Plant Health Losses

Avoidable Layoffs Cost U. S. 400 Million Man Days a Year, S. F. Conference Told

More than 400,000,000 man days of productive war work are lost annually to the Nation through sickness, industrial accidents and other avoidable layoffs, San Francisco's first Institute on Wartime Industrial Health was told yesterday.

The conference of 150 physicians, plant managers, industrial engineers, nurses and State and Federal authorities also was told that this manpower loss, if conserved, was enough to build 5,000 flying cargo ships which Henry Kaiser has proposed.

State's Problem

Because California leads the Nation in volume of war production, the State is faced with greater wartime health and industrial problems than the rest of the country, J. J. Bloomfield, of the United States Public Health, warned the meeting.

"Yet any war plant job can be done safely if there is real team work between plant management, the medical service, the engineering service and the employment department," he declared.

Coöperative Groups

Yesterday's conference was sponsored by the California State Department of Public Health and the San Francisco County Medical Society and was held in coöperation with the California Medical Association and the Western Association of Industrial Physicians and Surgeons.

Dr. Robert T. Legge, emeritus professor of hygiene at the University of California and past president of the association, presided over the meeting. Other speakers were Dr. John W. Cline, president of the San Francisco County Medical Society; Dr. Harold T. Castberg and Fred R. Ingram of the State department of health; C. H. Fry of the State industrial accident commission; Frank P. Foisie, president of the Waterfront Employers' Association, and Dr. Nelson J. Howard, professor of clinical surgery, Stanford University School of Medicine.—San Francisco *Examiner*, August 19.

* * *

Health Board to Crockett

'Women Pampered in War Plants'

The Institute on Wartime Industrial Health moved to Crockett for a one-day stand today following a first-

day meet here yesterday.

Sponsored by the California Department of Public Health in coöperation with the California Medical Association and the Western Association of Industrial Physicians and Surgeons, the Institutes are being held in seven California cities to aid the practicing physician, the industrial physician and the industrial plant manager in meeting wartime problems.

The conference of 150 physicians, plant managers, industrial engineers, nurses and State and Federal authorities yesterday was told more than 400 million man days of productive war work are lost annually to the nation, all of them through sickness, avoidable layoffs or industrial accidents.

Manpower hours lost would be enough to build 5,000 flying cargo ships of the type proposed by Henry Kaiser, it was said.

The conference was told that women in war jobs are being spoiled and pampered to protect them against the "ills that women are heir to." Actually, that's all the bunk and women can do four out of five jobs that men can handle; they can work just as long, just as hard and perhaps a lot more efficiently, the conference was told by Dr. Carey P. McCord, medical director of the Chrysler Corp. and a nationally recognized authority on industrial health.

The institute will move to Oakland Friday, San Diego, Aug. 25, Inglewood, Aug. 26, Glendale, Aug. 27, and Huntington Park, Aug. 28.—San Francisco *News*, August 19.

Three Institutes Slated on Health of War Workers

Three institutes on wartime industrial health are slated for the week of August 24 in Inglewood, Glendale and Huntington Park.

Health of war plant workers will be discussed. Subjects to receive attention will include conservation of industry's manpower, industrial hygiene and war production, occupational diseases and their controls, and surgical management of industrial injuries.

Physicians, safety engineers, industrial nurses and employers will attend. Noted medical experts will speak.

The Inglewood institute will be held August 26, at the Inglewood Country Club. Dr. John J. Durkin, president of the Inglewood branch of the Los Angeles Medical Society, will preside.

Dr. Carey P. McCord, medical adviser of Chrysler Corp., and national authority on industrial health problems, will be the principal speaker at all three meetings.

The Glendale session will be held August 27, at the Tuesday Afternoon Club. Dr. O. D. McCartney, vice-president of the Glendale Medical Society, will preside.

Dr. I. S. Cheery, president of the southeast branch of the county medical society, will preside at the Huntington Park institute on August 28, at the Women's Club.

The health institutes are part of seven arranged by the State Department of Health.

Noted doctors and specialists scheduled to speak include J. J. Bloomfield, of the National Institute of Health; Dr. Robert T. Legge, professor emeritus, University of California; C. H. Fry, State Industrial Accident Commission; Dr. Benjamin Frees, president of the Western Association of Industrial Physicians and Surgeons; Dr. E. E. Dart and Frank Stead, both of the Los Angeles Health Department.—Los Angeles *Daily News*, August 14.

Greatest Postgraduate Course in World

A short time ago, the American Medical Association held its annual meeting in an eastern city. Despite gasoline rationing, more than 8,000 physicians from all sec-

tions of the country attended. And that meeting was of importance to all the American people because it was a symbol of this country's preëminence in medical progress.

Doctors didn't come there for amusement. They came to listen, to learn, to see—to "talk shop." Six or eight motion picture theatres were in operation, showing medical films. There were special assembly halls for lectures, and scientific demonstrations were given on diabetes, heart disease, etc. Visitors from other nations expressed continuous amazement at the scope of the display. As one authority put it, the scientific exhibit was "the greatest postgraduate training course ever assembled anywhere in the world."

In war time, a meeting such as this takes on more than ordinary importance. Doctors discussed the advances that are being made in war medicine in treating patients suffering from horrible wounds. They discussed how the civilian population may be adequately served at a time when thousands of doctors are being called are problems that affect us all.

American medicine holds and will maintain world leadership, and with the hard years ahead, it will do more for suffering mankind than it ever did before.—Oakland *Saturday Press*, July 18.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Keep Doctors Healthy

Paul V. McNutt, chairman of War Manpower Board, recently pointed out that unreasonable demands on physicians' time must be avoided.

The necessity for this is apparent. Thousands of doctors have entered military service. By the end of this year, 20,000 additional physicians will be needed to serve our men in uniform. That need must be met, and it will be met. And one inevitable result will be a sharp decline in the number of doctors available to serve civilians.

Doctors in the larger towns and cities are "doubling up" in their desire to do all possible for all who really need their attention, and in the case of many country doctors, they are being continually called in to help out the city doctors who have their hands full or to supplement hospital staffs that have been reduced in numbers because of the ever increasing number of doctors and nurses who have answered the call to the colors.

This does not mean that anyone will have to go without necessary medical attention. It does mean that all must help so far as they can, to see that doctors are able to use their working time to the fullest advantage. To quote Mr. McNutt, on the doctor's part "it will mean long hours and hard work—sacrifices which will multiply the deep debt that every community owes to its physicians. There will be a real need to exercise every possible means for minimizing all unnecessary medical services."

In other words, you are asked to forego for the duration the "luxury" of wasting your doctor's time and energies. That is a real and necessary contribution to the

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Dwight H. Murray, Napa; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M. D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

war effort, and to the protection of civilian health as well since the doctor can not be up and around "on his toes" if he has had to spend the night holding the hand of some neurotic woman whose husband has "abused" her by not noticing her new hair-do.—Kerman *News*, July 31.

COMMITTEE ON HOSPITALS, DISPENSARIES, AND CLINICS

A Rhode Island Suggestion*

(COPY)

(Doctor: Post this notice prominently in your waiting room.)

SAVE YOUR DOCTOR'S TIME

The present emergency places many added responsibilities upon the doctor of medicine. Before the end of this year about one-third of the active practising doctors of this State will be doing military duty. The older doctors will be called upon to do the major part of the civilian work.

The doctor must make his calls geographically. Hence he must outline his work in different sections of the city at a reasonable hour in the morning. He must avoid calls to the same section of the city twice in the same day.

Coöperate with your doctor during the wartime emergency in the following ways:

1. If you desire a house visit, call the doctor around eight o'clock in the morning. This is a reasonable hour for most physicians. A person or child who has a temperature of 100° or over in the morning may be expected to have a higher temperature in the afternoon, so do not delay until you take the afternoon temperature.
2. Go to the doctor's office when you can, thus saving him the time necessary to make a house visit.
3. If you desire information on the telephone, help save his time by having a pencil and paper ready to note what instructions are given. If the patient is a child, do not take him to the telephone with you.

(Signed) PROVIDENCE MEDICAL ASSOCIATION.

Some New Hospital Procedures

(COPY)

Attending Medical Staff

THE CALIFORNIA HOSPITAL

1414 South Hope Street, Los Angeles

To the Members of the Staff, California Hospital:

Due to the present hospital operating conditions, it is important that the following regulations of the Executive Medical Board be carried out. You will realize that the present shortage of nurses, costs of supplies and the over-crowded conditions make it necessary to establish certain routine in order to render the best service to your patients.

A. Standardization of surgery routine:

In order to conserve supplies, the standard skin preparation prior to surgery will be the Harrington's Solution. Two alternate solutions will be on hand but they must be ordered specifically by the surgeon. These alternate solutions will be Tincture of Merthiolate and Tincture of Iodine.

B. Scheduling surgery:

New regulations of the American College of Surgeons make it necessary that all operating schedules show not

* Reproduction of text of a full page card in *Rhode Island Medical Journal*.

only the name of the operation, but the preoperative diagnosis or disease. Please give this information to the admitting nurse when scheduling surgery.

C. Time of entry of patients:

1. All patients being admitted for major surgery (except emergencies) must be entered in the hospital at 4:00 p.m. on the day previous to this surgery schedule. The admitting clerk is instructed to cancel the operating room schedule for the following day if the patient fails to arrive by 4:00 p.m.

2. Admitting minor cases (except emergencies) these cases should be in the hospital two hours before surgery. However, in tonsillectomy or similar operations, it is urged that these cases be admitted the day previous to surgery. If this is not feasible, it is requested that the patient report to the hospital one or two days before surgery for necessary laboratory work and history and physical by the intern.

D. The following regulations will also be effective in connection with floor nursing service:

1. All patients, whether private room or ward, who are up and around will bathe themselves.

2. No baths will be given on Sunday except to acutely ill patients and new postoperatives.

3. No back rubs will be given to patients in the evening, who are up and around.

4. No dressings will be done at tray time or after 7:00 p.m., except in cases of *absolute* emergency.

5. Carbogen inhalations require a great deal of nursing time and should only be ordered for patients with severe respirator depressions. Recommended procedure: Carbogen every 20 minutes (to point of hyperventilation) for first three hours.

Patients having spinal anesthesia: recommended procedure is deep breathing voluntarily instead of carbogen. It is recommended that where the above procedures cannot be carried out, special nurse should be ordered.

Your usual cooperation will be appreciated.

Very truly yours,

THE CALIFORNIA HOSPITAL.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

The Nurses' Aides

One of the most important jobs is that of being a nurses' aide. The Red Cross gives this training in hospitals of large cities, but it is likely that an unofficial form of training can be worked out for smaller hospitals, nursing homes, emergency outposts and private hospitals. This training must, however, be given only under the supervision of physicians and competent registered nurses.

The nurses' aide, when trained, does not replace the skilled care of the professional nurse. But she provides two hands and an intelligent head to turn to the smaller routine tasks which consume so much nursing time in hospitals. Doctors and nurses by the hundred keep going overseas. The supply of both is rapidly being depleted. If there should be an epidemic such as those of the last war, the country might be in as bad a way as it was then. Now, before any such disaster strikes, is the time to prepare. With the help of nurses' aides available, one experienced registered nurse can do the work of three. The doctor whose trained nurses are thus free for the more skilled and difficult jobs also finds his own time and energies multiplied.

A reporter investigating the matter brings in this informal word:

"As far as I can see the nurses' aides are about the only large organized group of volunteers who really work and keep to schedule and can be counted on. Real nurses think they're wonderful—which is something for a graduate nurse to say about volunteer help."

Knowing how to care for the sick never hurts any woman. In war or peace, life never fails to bring emergencies which make skill and knowledge useful.

A Priority on Nurses

To the 70,000 American nurses eligible for Army and Navy service:

There is a priority on unmarried nurses between the ages of 21 and 40 today. It is the priority of the Army and Navy on your services.

As America's armed forces extend their activities along every front in the fight for freedom, the need for your services is increasing. The Army and Navy must be supplied with at least 3,000 nurses a month.

That is why we appeal to you, the 70,000 nurses eligible for war service, to enroll with the Red Cross Nurses' First Reserve now. If you are a graduate registered nurse, in good health, unmarried, and under 40, write today to the Red Cross Nursing Service, Washington, D. C.

COMMITTEE ON PUBLICATIONS

Preparation of Papers for Publication*

In our efforts to improve the Journal we are faced with problems for the solution of which we ask the contributors' aid. Due to rising prices in general and to the increased cost of paper in particular, Journal costs are increasing. Space for scientific articles has been somewhat reduced by the creation of new departments made necessary by the war. For these and other reasons, we are submitting a list of suggestions to authors. If these are carefully followed, papers will decrease in length and increase in effectiveness.

Scientific articles should not exceed ten Journal pages and will be more carefully read if they are shorter than that.

Papers must be typewritten on one side only of white paper 8½ x 11 inches, double spaced throughout. The margins should be 1½ inches top and left side, 1 inch bottom and right side.

The pages, including tables, legends and bibliography, should be numbered consecutively.

The title should be brief and typed in capital letters. Under the title should appear the name of the author and the city in which he lives. His street address should appear at the end of the article.

There should appear in the text reference numbers typed above and to the right of the word to which there is a reference. The bibliography should be collected at the end of the article with the same reference numbers. The list should include the following items:

Books—author's surname followed by initials; title of book; edition; location and name of publisher; year of publication; volume; and page number. Thus, Osler, W.: *Modern Medicine*, ed. 3, Philadelphia, Lea & Febiger, 1927, vol. 5, p. 57.

Periodicals—author's surname followed by initials; name of periodical, volume, page, month (day if neces-

* This article appeared in the *Illinois Medical Journal*, Vol. 80, No. 4.

sary), year of publication. Thus, Leahy, Leon J.: New York State J. Med. 40:347 (March 1), 1940.

Spelling should be correct. When in doubt consult a standard dictionary. The Journal has not adopted the short form of through, thorough, etc.

Phony locutions. "He operated ten cases." The surgeon operates in a case but on a patient. The patient is not the case. The patient dies or recovers, the case terminates fatally or ends in recovery. "Cases in whom" should be "cases in which." "Patient in whom" is correct.

Many physicians have envied Sir William Osler his apparently easy command of English writing. In the Osler Library is a collection of some of his manuscripts showing the various stages of preparation. First there are notes of various kinds, then a rough outline in long-hand, next a typewritten copy with interlineations, transpositions and deletions, a second typewritten copy also showing much modification, and finally a third typewritten copy, probably used by the printer. Even this third copy bears minor corrections.

Illustrations. All cuts required for illustrations are furnished at the author's expense. For detailed instructions regarding photographs, drawings cost, etc., apply direct to the editor.

(Signed) THE EDITOR AND THE EDITORIAL BOARD.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (23)

Alameda County (8)

Harry J. Borson, *Berkeley*
A. Marion Field, *San Leandro*
Wm. Henry Hatteroth, *Oakland*
Julius Lewis, *Berkeley*
Robert Lewis, *Berkeley*
C. C. Morison, *Oakland*
Charles Callender Smith, *Oakland*
C. M. Wiseman, *Oakland*

Los Angeles County (1)

Floyd E. Harding, *Los Angeles*

Monterey County (1)

Charles Gratiot, *Monterey*

San Bernardino County (2)

Howard S. Downs, *Ontario*

Scott Ryerson, *Daggett*

San Diego County (6)

Clarence M. S. Ching, *San Diego*
McCleery Glazier, *San Diego*
George J. Laird, *San Diego*
Harry O. Lovell, *Pacific Beach*
Paul Harold Peterson, *San Diego*
M. D. Redding, *San Diego*

San Francisco (4)

Emma O. Dong, *San Francisco*
Edmund Dean Godwin, *San Francisco*
John J. Haman, *San Francisco*
Augustus Stiegler, *San Francisco*

Ventura County (1)

Kenneth F. Schneider, *Carmillo*

Listen attentively to the patient; he has lived with his disease longer than you have.

†For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Gidley, Donald Stanley. (Major, M.C., U.S.A.) Died at Fort Lewis, Washington, July 5, 1942, age 37. Graduate of the University of Oregon Medical School, Portland, 1930. Licensed in California in 1931. Doctor Gidley was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



Harbert, Ellis. Died at Stockton, July 16, 1942, age 76. Graduate of Vanderbilt University School of Medicine, Nashville, Tennessee, 1893. Licensed in California in 1894. Doctor Harbert was a retired member of the San Joaquin County Medical Society, and the California Medical Association.



Hogan, James Joseph. Died at Cincinnati, Ohio, July 14, 1942, age 70. Graduate of Cooper Medical College, San Francisco, 1892. Licensed in California in 1892. Doctor Hogan was a retired member of the San Francisco County Medical Society, and the California Medical Association.



Spiers, Homer Waldo. Died at Los Angeles, July 10, 1942, age 57. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1911. Licensed in California in 1912. Doctor Spiers was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



OBITUARY

Donald S. Gidley 1905—1942

Doctor Donald S. Gidley died at Fort Lewis, Washington, July 5, 1942, at the age of 37. He was a graduate of the University of Oregon Medical School, class of 1930, and was licensed in California in 1931. Dr. Gidley enlisted in the Medical Reserve Corps as a First Lieutenant in October, 1939, was promoted to a captaincy in October, 1940.

On March 1, 1941, he entered active service in the Medical Corps and received his majority on June 15, 1942. At the time of his death, he was the Regimental Surgeon at Fort Lewis. Major Gidley was in active practice in Ontario and a member of the San Bernardino County Medical Society and the California Medical Association, and was also a Fellow of the American Medical Association.

Outlook for Mumps Control Improved.—An outbreak of mumps in a military establishment may lead to serious consequences in the way of days lost through hospitalization, Conrad Wesselhoeft, M. D., late Captain, Medical Corps, United States Army, Boston, and Charles F. Walcott, M. D., Major, Medical Corps Reserve, United States Army, Cambridge, Mass., declare in the current issue of *War Medicine*, published bimonthly by the American Medical Association in coöperation with the Division of Medical Sciences of the National Research Council.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939.....	1,220
March, 1940.....	9,322
November, 1940.....	19,990
May, 1941.....	27,057
November, 1941.....	32,199
May, 1942.....	38,061
July, 1942.....	34,520

The physicians of the State may like to know some of the background which resulted in the changes which are now being made in California Physicians' Service. The changes were designed primarily to bring unit value to a par basis. It may be of interest to compare the method with those of other well-known plans seeking the same end result.

All medical plans recognize the necessity of complete solvency in order to be successful. Solvency is one factor which eventually influences physician-patient relationships. It, of course, represents also the satisfying of the final objective, which is the solution to the riddle of medical economics. The distribution to the public of the advances of medical science is the fundamental which has created the necessity for the development of some plan to meet this need. The premise from which all pre-paid medical service plans start is as follows:

"A fundamental characteristic of an insurable hazard is that the frequency of the happening of the event which is the subject of the insurance should be subject to prediction within reasonable limits of error.

"A necessary corollary is that the happening of the event must not be subject to the control of the insured individual, or that there must be a strong incentive or desire on the part of the insured individual to avoid the happening of the event which is the subject of the insurance.

"It is equally necessary that the insured event shall be susceptible of precise and easily understood definition."

The readiness and frequency with which medical service is sought and the extent to which services may be rendered are factors of human conduct which are not susceptible of precise definition. It is this last which we feel has been responsible for the abnormal use of service experienced by California Physicians' Service during the past three years. We have demonstrated that the human conduct of the Medical Profession in handling thousands of patients can be trusted and relied upon. This has become a measurable factor with many constants which can be projected into the factor of various caseloads under various conditions. On the other hand, the beneficiary member has reacted in a manner that was unforeseen. All available figures indicated that the sickness rate for the average population would be 5 per cent to 7 per cent. Our predictions, under our plan, provided for double this. As time has gone along, we found that we were too conservative in our estimates. Figures month after month and then, beginning a sequence of years, showed that we were being called upon to handle three times the normal. Many of us were expecting a ripening process in time, due to the clearing up of old conditions, but we became convinced that this was not going to happen. We

knew some changes had to be made, but we also knew that these changes must meet certain requirements.

Primarily, C.P.S. had to develop a contract that would automatically control abuses. We believe that appealing to the human factor, in which there is a responsibility on the part of the prospective patient in seeking medical service, will help achieve this end. This is the basic provision for the surgical contract, in which a cutting procedure is the benefit. People do not subject themselves to this kind of treatment unnecessarily. When medical care is desired, the member can purchase the two-visit deductible contract in which he is called upon to pay for the first two visits to the attending physician. This puts the financial responsibility on the patient and, at least, stimulates thought before a doctor is called.

C.P.S. experience has shown that the use of service under the old full coverage was approximately 20 per cent, whereas, under the two-visit deductible, use was reduced to 4 per cent. We do not believe the welfare of the member is affected by this provision, since C.P.S. provides complete care for illnesses of consequence and the patient can feel that he has an adequate protection for unforeseen illnesses.

We could not have felt quite so secure in our position in making these changes if it were not for the fact that, as mentioned above, the medical profession of the State, as a whole, has cooperated fully in the program. It is quite evident that, when doctors work with doctors, the elements of suspicion, the tendency to pad bills, and the feeling that the individual physician is hampered in what he can do for the patient from a medical point of view, disappears. Since the medical profession has demonstrated quite conclusively that these factors may be relied upon, it places the Plan in a better position to succeed than any other type of administrative set-up so far conceived.

The human factor is an important element which must be considered in measuring results obtained, and our experience may point the way toward a type of administrative set-up that will work to the advantage of the medical profession, as well as to the welfare of the public. It is on such intangibles that success or failure of any endeavor involving human relations must depend.

MEDICAL EPONYM

Morton's Toe

Thomas G. Morton (1835-1907), surgeon to the Philadelphia Orthopedic Hospital, described this condition in a paper, entitled "A Peculiar and Painful Affection of the Fourth Metatarso-Phalangeal Articulation," published in the *American Journal of the Medical Sciences* (71:N. S.: 37-45, 1876). He reported 15 cases, 13 of which were in women. All the patients complained of severe pain localized in the fourth metatarsophalangeal articulation. It was generally relieved by removal of the shoe. Some patients told of having to stop in the street for this purpose. Morton advised operation for the relief of chronic cases. The origin of the condition is described as follows:

"To the peculiar position which the fourth metatarsophalangeal articulation bears to that of the fifth, the great mobility of the fifth metatarsal, which by lateral pressure is brought into contact with the fourth, and lastly, the proximity of the digital branches of the external plantar nerve, which are under certain circumstances liable to be bruised by or pinched between the fourth and fifth metatarsals, may be ascribed the neuralgia in this region."—R. W. B., in *New England Journal of Medicine*.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization. For roster of non-profit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.

American Medical Association, San Francisco. Date of 1943 Session not yet decided.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of September, 1942:

Saturday, September 5—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, September 5—KECA, 10:30 a.m., The Road of Health.

Saturday, September 12—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, September 12—KECA, 10:30 a.m., The Road of Health.

Saturday, September 19—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, September 19 and Saturday, September 26—KECA, 10:30 a.m., The Road of Health.

Saturday, September 26—KFAC, 8:45 a.m., Your Doctor and You.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Pharmacological Items of Potential Interest to Clinicians (From the U. C. Pharmacologic Laboratory—Chauncey D. Leake, Director):

1. *More Books:* International Publishers in New York go to town with W. H. Gantt's translation of I. P. Pavlov's essays from 1928 to 1936 on *Conditioned Reflexes and Psychiatry* (1941), and F. Schoff and W. C. Boyd's *Blood Grouping Technique* (1942; both well illustrated, the former has important biographical introduction, the latter is well documented. L. T. Webster issues neat summary on *Rabies* (MacMillan, N. Y., 1942). Timely and richly illustrated is A. R. Moritz's *Pathology of Trauma* (Lea and Febiger, Phila., 1942). E. A. Evans edits symposium on selected recent aspects of *Biological Action of Vitamins* (Univ. of Chicago, 1942). E. R. Squibb & Sons (N. Y., 1942) offer a *Physicians' Reference Book of Emergency Medical Service*, which is fine for war work—except section on war gases which follows "official" pamphlets in making too much of identification and specific treatment. Excellent is W. C. Hueper's *Occupational Tumors and Allied Diseases* (C. C. Thomas, Springfield, Ill., 1942), with full discussion of chemical effects.

2. *General Culture, Fore and Aft:* If you want to know Aristotle, get the Random House one volume issue of the Oxford translations, with commentary (N. Y., 1941). J. J. Izquierdo gives a good account of Claude Bernard with translation (Spanish) of the Introduction to the Study of Experimental Medicine (Univ. of Mexico, 1942). Significant is Volume VIII of *Biological Symposia on Levels of Integration in Biological and Social Systems* (Cattell Press, Lancaster, Pa., 1942). Take note of Eliot Blackwelder's *Science and Human Prospects* (Thinker's Forum No. 19, Watts, London, 1942).

3. *War Medicine:* Here's success to Lippincott's *Clinics*, Volume I, No. 1 (June, 1942) of which contains a helpful symposium on burns and shock. F. V. Stonham (*Med. J. Austral.*, 1:611, May 30, 1942) in discussing late treatment of war wounds finds that direct contact of cloth dressings impedes healing, but that closed plaster methods are O.K. C. Lyons and C. Burbank review local sulfonamide therapy (*Surg. Gyn. Obs., Internat. Abs. Surg.*, 74:571, 1942). Well documented symposium on plasma concentrates in transfusion in *Texas St. J. Med.*, (37:195, 1942). Committee on Chemotherapy National Research Council (*War Med.*, 2:488, 1942) recommends high vitamin intake daily for wounded patients until recovery. If you're interested in war gas action, and haven't yet seen P. C. Livingston and H. M. Walker's study of the effects of mustard on the eyes, look it up (*Brit. J. Ophth.*, 24:76, 1940).

4. *Research and Teaching:* A. E. Casey (*Science*, 96: 110, July 31, 1942) shows high correlation between productive research in medical schools and effectiveness of teaching; similar correlation might be shown between State Board performance and intellectual character of medical student! Maybe good men go to good schools.

5. *Here and There:* J. L. Morrison and G. A. Emerson find that steep gradient of butyl-bromoalyl-barbituric acid distribution in central nervous system is effective in antidoting metrazol and strychnine convulsions, but not cocaine (*Anesth. and Anal.*, 21:213, 1942). K. Dunlap and R. D. Loken (*Science*, 95:554, May 29, 1942) rec-

commend high vitamin A intake for "clearing" color blindness. L. Farmer and R. Fribourg (*Proc. Soc. Exper. Biol. Med.*, 50:208, 1942) find that thyroid extract increases sensitivity to histamine by depleting adrenals of cortin. C. L. Rose, P. N. Harris and K. K. Chen (*Ibid.*, p. 228) report on toxicity of dicumarol (2 mg per kg IV; 5-50 mg per kg orally). W. S. Preston, W. D. Block and R. H. Freyberg (*Ibid.*, p. 253) find that sulfur is not necessary in gold compounds for effective chemotherapy of arthritis (in mice). A. D. Hirschfelder and G. Tamcales (*Ibid.*, p. 272) note that procaine may inhibit auricular fibrillation. G. L. Hobby, K. Meyer and E. Chaffee (*Ibid.*, p. 277-288) add much to knowledge of action of penicillin. M. Prinzmetal, G. A. Alles, et al (*Ibid.*, p. 288) report that heat-inactivated tyrosinase preparations can produce lowering of blood pressure and remission of symptoms in hypertension. J. B. deC. M. Saunders, J. Nuckolls and H. E. Frisbie make fundamental contribution to histology of enamel and to amelogenesis (*J. Amer. Coll. Dent.*, 9:107, 1942).

Dr. Chauncey D. Leake leaves University of California: Has Accepted Position in University of Texas Medical School.—Appointment of Dr. Chauncey D. Leake, head of the University of California department of pharmacology and librarian of the university's medical school, as executive vice-president of the University of Texas medical branch at Galveston, was announced yesterday.

Doctor Leake has been with the University of California since 1928.

His appointment was officially announced by Dr. Homer Price Rainey, president of the University of Texas, according to Associated Press reports.

In his new position, Doctor Leake will be dean of the medical branch of the university and will also have administrative jurisdiction over the John Sealy Hospital and the College of Nursing at Galveston.—*San Francisco Examiner*, August 23.

World at War Notes Anniversary of Treaty Founding Red Cross.—A war-engulfed world on August 22 will note the 78th anniversary of the signing of the Treaty of Geneva, under which the International Red Cross Committee was established.

Signed in 1864, the treaty provided the foundation of the 61 Red Cross societies, including the American Red Cross, in existence today.

Out of the treaty also grew methods of providing humanitarian care for sick and wounded soldiers, regardless of nationality, in war-time, and the protection of hospitals, ambulances, and personnel caring for them on the field of battle. Subsequent treaties extended these services and also provided for reciprocal agreements between nations for the better treatment of prisoners of war. Headquarters of the International Red Cross Committee still are in Geneva. Since last December it has handled thousands of inquiries from the American Red Cross on the whereabouts of missing soldiers and captive civilians in belligerent countries. It also is the clearing house through which the American Red Cross obtains delivery of food, clothing and medical supplies to Americans who are prisoners of war.

Signing of the treaty was brought about through the efforts of Henri Dunant, a Swiss idealist.

Insulin Comes of Age.—Twenty-one years have passed since the discovery of insulin, which brought the Nobel prize to Banting and his associates, and gave a renewed lease on life to numberless sufferers. The patent on the manufacture of insulin, held by the University of

Toronto, expired at the end of last year, and the maintenance of adequate standards of purity and strength is, in this country, now controlled by the United States Food and Drug Administration. Since those early days in the University laboratory, where the first crude insulin was prepared, research has continued unremittingly, and today improved forms of insulin are available, one of which, by its more gradual action, approaches the normal physiological function of the human product. To the current generation of doctors trained in the modern treatment of diabetes, the distressing outlook for the diabetic in pre-insulin days is a matter of historical record rather than of personal experience.

In this experience, as in the general population, it is in childhood and in early adult years that the greatest reduction in mortality has taken place, and, indeed, when attention is thus concentrated on a group of actual diabetics, the reductions at these ages are spectacular. At ages under 20, for example, the death rate has been cut to as little as 3 per cent of the very high rate prevailing in the pre-insulin era. At ages 20 to 39 the recent rate is only 5 per cent of the death rate before insulin. At higher ages the improvement, though not so spectacular, is still very considerable.

Further light on the effect of modern treatment is brought out by such as pneumonia and influenza, has taken a sharp drop, to little more than one-third of the former rate; and with the success in the use of sulfa drugs, which were introduced only at the end of the 10-year period here covered, the prospect is for still further reduction.

It is instructive to express the improvements in mortality in terms of the corresponding gains in longevity. Today, the average diabetic child of 10 may be expected to celebrate his 50th birthday, whereas just prior to 1922 most diabetic children lived little more than one year after the onset of their disease.

Scientist Says 1980 Outlook Is One Child to a Home.—Paul C. Glick of the United States Census Bureau predicts that by 1980, American families will average only one child each.

Supported by figures, Glick discussed the declining national birth rate at the annual meeting of the American Sociological Society.

The first census of the United States, taken in 1790, showed more families of five persons than any other number. A century later, the number of children per family had dropped to four.

"In 1900, the census revealed only three persons to a family," Glick said, "and by 1930 the family size had been reduced to two, thus revealing that in 140 years the typical family size had changed from five persons to two."

Forecast for 1980

Glick forecast that by 1980 there would be fewer than one child under 21 years old residing in the average family.

Smallpox Now at Lowest Ebb in U. S.; Danger Seen in Population Shifts.—An all-time low record for smallpox in the United States was set in 1941, but health authorities warn against overconfidence about the smallpox situation.

An increase in smallpox cases can confidently be predicted, they point out, if people generally get the false notion that vaccination against smallpox can be dispensed with. In that case the growing number of unprotected persons will provide a new fertile field for a resurgence of the disease.

The shift, because of the war, of thousands of fami-

lies of war workers from smallpox areas to cities previously free of smallpox may lead to outbreaks in these cities. The best protection against this danger is a widespread and vigorous campaign for vaccination, including revaccination of adults.

Only 1,432 cases of smallpox were recorded for the entire country for the year 1941. Chief center for smallpox in the United States in past years has been in the northwestern corner of the country. Montana, Washington, Idaho, and Oregon have generally been the states with the highest incidence, with the states adjacent to these four having next highest rates.

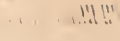
Outstanding exception to the rule of low smallpox incidence in the rest of the country is Indiana. During the past 20 years this state has had about four times the number of smallpox cases recorded by all of the New England and Middle Atlantic States plus Delaware, Maryland and the District of Columbia, although its population is less than one-tenth that of the eastern region.

California

Art Work of California Physicians.*—A list of physicians whose work in art is illustrated in "*Parergon—Work by the Side of Work*," follows:

TITLE OF SUBJECT	NATURE	NAME OF ARTIST
Indian Road	Oil	J. Francis Smith, M. D. Los Angeles
Mixed Flowers	Oil	John Tavlopoulos, M. D. San Francisco
Jonquil	Oil glass paper	Thomas M. Potasz, M. D. Los Angeles
Flowers in the Green Vase	Oil	Ruth A. Knoph, M. D. San Francisco
Off for a Ride	Photograph	F. W. Hodgdon, M. D. Pasadena
Monterey Fishermen	Photograph	R. A. Kocher, M. D. Carmel
Capistrano Mission	Oil	E. F. Maginn, M. D. Los Angeles
Textures, Old and New	Photograph	Mary H. Layman, M. D. San Francisco
Weathered	Photograph	K. C. Ashley, M. D. Los Angeles
Seascape	Oil	Francis H. Redewill, M. D. San Francisco
Shadows	Water color	Martha Mottram, M. D. San Francisco
Fairyland	Miniature relief	Lokrantz, Sven, M. D. Los Angeles
Sierra Lake	Oil	E. R. Lambertson, M. D. Los Angeles
Tennessee Chain Gang	Wood	Rachel E. Arbuthnot, M. D. Glendale
Mission Valley	Oil	J. C. E. King, M. D. San Diego
Dr. Joseph P. Widney	Bronze	Emil Seletz, M. D. Los Angeles
Perpetual Snow, Mt. Rose	Pastel	W. H. Strietmann, M. D. Oakland
Calodium	Pastel	Mary Hess Brown, M. D. Los Angeles
San Mateo Hills	Oil	Asa Collins, M. D. San Francisco
Near San Diego	Oil	Saul S. Robinson, M. D. Los Angeles
A Priest at the Temple of Shiloh	Sculpture	Arthur Smith, M. D. Los Angeles
Patriarch	Penknife carving from avocado seed	Harry Fist, M. D. Los Angeles
Canyon in Utah	Oil	Paul K. Sellev, M. D. Los Angeles
Persia	Oil	Louis Guggenheim, M. D. Los Angeles
Lebenslust	Plaster	Henry G. Bieler, M. D. Pasadena
Lilies of the Field	Photograph	G. J. Hall, M. D. Sacramento
Figure in Repose	Oil	R. H. Kennicott, M. D. Los Angeles
Composition from Life Magazine	Oil	L. J. Courtright, M. D. San Francisco
Ojai Sycamores	Water color	Neville T. Ussher, M. D. Santa Barbara
Maryann	Color photo- graph	John Budd, M. D. Los Angeles
Bowl	Wood carving	Robert A. Campbell, M. D. Los Angeles
Navajo	Photograph	Burt L. Davis, Jr., M. D. Palo Alto
Landscape	Oil	Ernest H. Nast, M. D. San Francisco
Juilley	Oil	F. L. Mullen, M. D. San Francisco
Little Lady Make Believe	Photograph	J. Edwin Scobee, Jr., M. D. Los Angeles
Rocky Coast	Oil	A. W. Dowd, M. D. Santa Monica
Jitterbug	Photograph	Abraham Marians, M. D. Los Angeles
Man with Long Nose	Plaster	Monte Salvin, M. D. Los Angeles
Belvedere Landscape	Oil	S. P. Lucia, M. D. San Francisco
Inward Bound	Water color	R. Proctor McGee, M. D. Los Angeles
Artichoke Ranch	Oil	Lewis Sayre Mace, M. D. San Francisco
"George"	Photograph	A. W. Henry, M. D. San Leandro
Burgomaster 1938	oil	R. J. Pickard, M. D. San Diego
Water Jug	Seal satin skin ceramic	Paul E. Wedgewood, M. D. San Diego
Portrait	Charcoal	Joseph C. Savage, M. D. Los Angeles
Duchess of Windsor	Crayon	R. de R. Barondes, M. D. San Francisco
At Dawn	Wood	R. W. Burlingame, M. D. San Francisco
The Prisoner	Terra cotta	J. K. Moore, M. D. Los Angeles
Lincoln	Pencil	Ernest M. Hall, M. D. Los Angeles
Hopi Owl	Water color	S. H. Babington, M. D. Berkeley
Rain God	Oil	Marcia A. Patrick, M. D. Los Angeles
Penguins	Oil	Frederic Ewens, M. D. Beverly Hills
Wood Sculpture	Wood	H. B. Graham, M. D. San Francisco
Portrait	Plaster	Dell T. Lundquist, M. D. Palo Alto
Silliman Peak	Photograph	Frank E. McCann, M. D. Monrovia
"Happier Days" (Bavarian Herder)	Photograph	Albert D. Davis, M. D. San Francisco
Mask	Carved walnut	Ethel Lynn, M. D. San Francisco
Man's War-Lust Strikes	Oil	Salvatore Monaco, M. D. Los Angeles
Sgraffito Vase	Pottery	H. L. Thompson, M. D. Los Angeles
Storm Over Yosemite	Photograph	Llewellyn Lewis, M. D. Los Angeles
La Lavendera	Photograph	George Dock, M. D. Pasadena
Mitten Butte, Monument Valley, Utah	Photograph	Peter N. Fisher, M. D. Van Nuys
William Rhodes Harvey	Sculpture	J. M. Olmsted, M. D. Berkeley
Rush Hour, En- senada, Mexico	Water color	Katherine M. Close, M. D. Los Angeles
Magnolia Bud	Water color	Philip S. Doane, M. D. Pasadena
Bunch of Oranges	Orangewood carving	Edward S. Ruth, M. D. Los Angeles
The Pioneeress	Plaster	S. Maisler, M. D. San Francisco
Mother	Sculpture	George D. Maner, M. D. Los Angeles
Pacifica	Photograph	Cyril B. Courville, M. D. Los Angeles
Harvey Cushing	Bronze	Albert A. Best, M. D. Los Angeles
Billroth	Clay	Otto P. Diederich, M. D. Fresno
Portrait	Plaster	Frank L. Dennis, M. D. San Diego
Set of Bowls	Wood carving	

* For editorial comment in this issue of C. and W. M., see page 172.

Pressure is	Marble	Hans Briesen, M. D.
Determined,		Los Angeles
Unceasing		
Penguin	Carving	David S. Alpert
		Los Angeles

Plague Infection in Human Beings Reported in the United States During 1941.—Two fatal cases of plague in human beings were reported in the United States in 1941, both in Siskiyou County, California. The first case occurred in a 10-year-old boy, residing near Montague, with onset on June 14 and death on June 26. The diagnosis was confirmed bacteriologically. The second case occurred in a 5-year-old boy living 1 mile northwest of Mount Shasta City, about 50 miles from the locality in which the other case occurred. The diagnosis was confirmed by animal inoculation and the isolation of pure cultures.

The source of infection in each case was believed to have been ground squirrels; and the distance between the two localities in which the cases occurred indicated widespread rodent infection in the area. This was subsequently proved to be the case by the finding of plague infection in pools of fleas taken from ground squirrels in various localities in Siskiyou County.

Plague infection in rats, wild rodents, and parasites from rodents was reported during 1941 in 8 western states—California, Colorado, Idaho, Montana, New Mexico, North Dakota, Oregon, and Washington. It was found for the first time in North Dakota. On July 12, 1941, the infection was proved in fleas collected on June 23 from ground squirrels (*C. richardsonii*) shot in a locality about 7 miles northeast of Crosby, Divide County, and about 6 miles south of the Saskatchewan-North Dakota boundary. It is believed that this locality is the farthest east in which plague infection has been found in wild rodents or their ectoparasites in the United States. The farthest east where the infection had previously been proved to be present was Dona Ana County, New Mexico, where an infected kangaroo rat was found in 1939.

Infected rats and infected fleas from rats were found in San Francisco and Richmond, Contra Costa County, California, during the year.

Antisymphilitic Agents Discovered by Stanford School of Medicine.—Nearly a half a million cases of syphilis have been arrested, if not cured, during the past nine years through the use of iodobismitol and sobisminol, two antisymphilitic agents discovered and developed by the Stanford University School of Medicine.

This estimate is based on the total sales by distributors of the two products and the amount of the compounds used in the effective treatment of syphilis, according to Dr. P. J. Hanzlik, head of the Stanford department of pharmacology. He estimates that 740 000 full therapeutic courses of antisymphilitic treatment of the bismuth compounds have been given by practicing physicians, hospitals, and clinics. Iodobismitol is injected intramuscularly, and sobisminol, which was developed only two years ago, is taken by mouth. Dr. Hanzlik said:

"As a result of the discovery of these two bismuth compounds by systematic researches over a period of 13 years, Stanford University has directly contributed tangible benefits to human society, and there is reason to believe that similar benefits from the same source will continue."

Although there have been other agents for treating syphilis, sobisminol and iodobismitol are especially effective in controlling neurosyphilis, one of the later and most dangerous stages of the disease which attacks the brain and nervous system.

American College of Physicians.—At the Annual Meeting of the American College of Physicians, held in Atlantic City, June 6-8, 1942, John C. Sharpe, M. D., of Salinas, was elected a member of the Board of Governors of the college.

Interesting scientific programs were presented at the meeting and constructive plans laid out for the future.

Congress of the American College of Surgeons Scheduled for Cleveland, November 17 to 20.—The 1942 Clinical Congress of the American College of Surgeons (address, 40 East Erie Street, Chicago), originally scheduled for October at the Stevens Hotel, Chicago, which was taken over August 1 by the United States Army Air Corps, will be held in Cleveland, with headquarters at the Cleveland Public Auditorium, from November 17 to 20, according to an announcement from the College headquarters in Chicago. The twenty-fifth annual Hospital Standardization Conference sponsored by the College will be held simultaneously.

The program of panel discussions, clinical conferences, scientific sessions, hospital meetings, and medical motion picture exhibitions at headquarters, and operative clinics and demonstrations in the local hospitals and Western Reserve University School of Medicine, has been centered around the many medical and surgical problems arising out of the prosecution of all all-out effort to win the war, emphasizing the needs of the rapidly expanding medical services of the Army and the Navy, and consideration of special problems related to the increasing activities for civilian defense.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

What Is Rabies?

Rabies is an acute and highly fatal disease, generally communicated to man through a wound by the teeth of some infected lower animal, the saliva being the infective medium. Dogs, cats, goats, cows, horses and other animals are susceptible to the disease and their bites are very dangerous. Rabies may also be contracted by allowing the saliva of an infected animal to come in contact with a cut or abrasion on the hand or other part of the body. This sometimes happens in adjusting muzzles or administering medicine; therefore, great care should be used in such operations, for it has been proven that in the case of the dog the saliva is virulent (infectious) from twenty-four to forty-eight hours before the dog shows any signs of being sick.

The main factors necessary to observe for the precaution against rabies are (1) keep your dog on your own property, properly enclosed and safeguarded; (2) when taken out within the city limits, have him securely leashed; (3) report stray dogs to the City Humane Department, Michigan 5211, Station 2323; (4) when bitten by a dog, have the wound cauterized with fuming nitric acid by your own physician, or report immediately to the nearest emergency hospital or police station for treatment, then report the incident in detail for your own protection to the Los Angeles City Health Department, Rabies Control Division, Michigan 5211, Station 429.

An outbreak of rabies in the Harbor area has been successfully terminated and brought under control by strict policing and spot quarantining; 8776 homes were contacted, 2503 dogs were placed under 90-day quarantine, and 2318 placards were placed on homes giving owners quarantine instructions. One human life was lost in this outbreak; however, it was through no fault of this division, as the victim was instructed to report to the Health Department for treatment and did not do so.

The Rabies Control Division wishes to thank the medical and veterinary professions for their splendid cooperation in reporting dog bites and treatment to us with the least practicable delay.—Los Angeles City Health Department *Bulletin*.

* * *

Stanford, U. C. Speed Medical Training

Stanford and the University of California will graduate about 280 doctors of medicine in the next three years in-

stead of four, under a wartime speedup program, the California Medical Association said today.

This is part of the record breaking plan to graduate 21,000 physicians from American medical colleges in the next three years announced today by the American Medical Association Council on Medical Education. The figure represents 5000 more than would have graduated in that period under a normal program.

Each of the two schools graduates approximately 70 doctors a year, the state association said. Under the speedup plan the students' 36 months of training will run without interruption rather than through 48 months. California deans took this step a year ago.

Nationally the program provides more than two graduating physicians for every death of a practicing doctor.

The council reported the increased graduation of doctors was being accomplished in 53 approved medical schools with no sacrifice of educational standards.

The four-year course has been reduced to three by elimination of summer vacations, with the result that a class is graduated every nine months.

In addition, approximately 220 United States citizens will graduate during the period from Canadian medical schools, the report said.

Arrangements have been made to license the short course physicians in 41 states, the District of Columbia, Alaska and Puerto Rico. Seven states, Georgia, Illinois, Kansas, Michigan, Nebraska, New Jersey and South Carolina, do not permit granting of licenses to the short-term students but corrective legislation was being sought. —San Francisco News, August 13.

* * *

Many Cases of Syphilis Arrested by Stanford-Developed Agents

Nearly half a million cases of syphilis have been arrested, if not cured, during the past nine years through the use of iodobismutol and sobisminol, two antisyphilitic agents discovered and developed by the Stanford University School of Medicine.

This estimate is based on the total sales by distributors of the two products and the amount of the compounds used in the effective treatment of syphilis. Dr. P. J. Hanzlik, head of the Stanford department of pharmacology, said today. He estimates that 740,000 full therapeutic courses of antisyphilitic treatment of the bismuth compounds have been given by practicing physicians, hospitals, and clinics. Iodobismutol is injected intramuscularly, and sobisminol, which was developed only two years ago, is taken by mouth.

"As a result of the discovery of these two bismuth compounds by systematic researches over a period of 13 years, Stanford University has directly contributed tangible benefits to human society, and there is reason to believe that similar benefits from the same source will continue," Dr. Hanzlik said.

Although there have been other agents for treating syphilis, sobisminol and iodobismutol are especially effective in controlling neurosyphilis, one of the later and most dangerous stages of the disease which attacks the brain and nervous system. —Palo Alto Times, August 13.

* * *

Sulfa Drugs Are Proving Great Boon to Mankind

The American Medical Association reports sulfa drugs are saving seventy-five out of every 100 patients stricken with influenza meningitis and about ninety out of every 100 with meningococcus meningitis. These figures were obtained from tests conducted in public hospitals and there is no reason to believe they do not represent a fair cross section of the results to be expected.

Before the sulfa derivatives were tried, the mortality was exceedingly high, ranging up to 100 per cent in influenza meningitis.

No less startling is the record achieved in treating battlefield injuries. The sulfa drugs have proved to be among the outstanding recent developments in medical science.

Without them many more American fighting men would have been entered in the fatality table. Without them many a baby would have lost its life.

War is horrible at best but it is a blessing to all humanity when something is discovered which tends to restrict its scars. And the same certainly can be said when new treatment insures longer life and tempers or routs altogether the effect of hitherto fatal maladies.

The sulfa drugs deserve no less a distinction than to be acclaimed as one of modern medicine's greatest boons to mankind. —Fresno Bee, August 14.

* * *

Vallejo Is Given \$1,750,000 Fund for New Hospital

Vallejo, Aug. 18.—President Roosevelt has approved

Vallejo's new \$1,750,000 hospital project, according to telegraphic word received here last night from Congressman Frank H. Buck.

The 250-bed hospital, now listed as an official city project, probably will be operated by the city in conjunction with the Solano County Medical Association, according to Perkins. In addition to the hospital proper the project also includes a 100-bed nurses' home.

The hospital, Perkins said, will be located close to the juncture of Sonoma Street Extension and the Napa Road, two miles north of the city proper.

All plans and specifications for the hospital, which will be staffed by Vallejo doctors, have been completed, Perkins said, and it will be possible to begin excavation operations within two weeks, if the contract is let. —Oakland Tribune, August 18.

* * *

Hospital to Be Dedicated

Kaiser Institution for Shipyard Workers to Be Opened Friday

The Permanente Foundation Hospital, established to increase the efficiency of war workers at the three Richmond shipyards, sponsored by the organization of Henry J. Kaiser Company, will be dedicated Friday.

The ceremonies will begin at 2 p.m. at the MacArthur Boulevard and Broadway site, with Joseph R. Knowland, publisher of The Tribune, serving as the principal speaker.

Clay Bedford, general manager of the three yards, will act as master of ceremonies.

Other speakers will be Dr. Benjamin Black, Alameda County medical director, and Dr. John F. Slavich, Mayor of Oakland. The Rt. Rev. Noel Porter, Episcopal Bishop of Sacramento, will deliver the invocation and benediction.

Complete Equipment

The hospital, one of the most modern in the Bay area, provides complete facilities for the care of the thousands of workers brought to Metropolitan Oakland by the Richmond yards. It has a clinic for "out" patients, with pharmacy, physiotherapy and x-ray rooms and emergency surgery on the first floor; rooms and wards for "in" patients on the second and third floors, and three surgeries on the fourth floor.

Approximately \$333,000 was expended on land purchase, building and equipment. The original structure, once a part of the old Fabiola Hospital that was closed in 1932, was of reinforced concrete construction.

Beds Provided

Accommodations have been provided for 55 "in" patients and, according to Edward Dodds, superintendent of construction for California Kaiser Company, an additional 20 could be handled in the event of a disaster.

A field hospital has been established at the yards in Richmond by the U. S. Maritime Commission.

The Permanente Foundation was founded by Mr. and Mrs. Henry J. Kaiser. Both the Permanente Foundation Hospital and facilities were provided by them and transferred to the Foundation.

Fourfold Purpose

Purpose of the Permanente Foundation is fourfold. First, it will establish hospital facilities for war workers which are not now available. Second, it will provide funds for research into industrial medicine. Its third objective is to set up fellowships for the training of physicians and nurses in specialties; its fourth, to provide modern medical facilities in rural as well as urban areas. The urban facilities will, the Foundation anticipates, offer inducements for young doctors leaving the armed forces to enter practice in non-metropolitan districts where there exists a shortage of doctors. —Oakland Tribune, August 19.

I believe that it is up to the health department to assume leadership and responsibility for a broader field of public health. Our job should be something more than preventing disease and reducing death rates. Good health, not mere survival, is of the greatest importance to mankind. Happy and wholesome living should be our goal. The success of our activities for the attainment of a maximum of health for the people will depend upon wise planning, efficient operation, and constant employment of practical measures.—JOHN L. RICE, M.D., Commissioner of Health, New York City.

Following the line of least resistance is what makes men and rivers crooked.—Blemis Blotter.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

San Francisco

Importance of X-ray Examinations

A constantly reoccurring source of litigation is the alleged failure of a physician to correctly diagnose an injury or ailment when he is first consulted. The result of an improper diagnosis may be that a harmful course of treatment is prescribed, and when the patient discovers the mistake he brings a court action against the physician for malpractice. The rule is usually stated to be that a physician does not insure the correctness of his diagnosis. However, a patient is entitled to an ordinarily careful and thorough examination such as the circumstances, the condition of the patient and the physician's opportunities for examination will permit. Honest errors of judgment are excused in cases where physicians might reasonably arrive at different interpretations of the symptoms displayed, but no physician may relieve himself of responsibility unless he has first exercised ordinary and reasonable care and skill, and has given the patient the benefit of his best judgment.

The necessity for utilization of approved methods of diagnosis is demonstrated in the case of *Burford v. Baker*, 53 A.C.A. 337 decided by the California District Court of Appeal on July 8th, 1942. The plaintiff in this case was a minor of the age of fourteen years who was the victim of an automobile accident. On the day of the accident, and soon after it occurred, he was taken to the office of the defendant, an osteopathic physician, who had been acting as the family physician for some years, treating the plaintiff for various ailments including a glandular disturbance. The boy walked with a noticeable limp at the time the defendant was first consulted and his hip was discolored and swollen. The defendant failed to follow the suggestion of the plaintiff's father that an x-ray be taken, and after examination, stated that the injury was only a bruise or muscle strain which should be treated by the application of hot towels. When the injury did not respond to this treatment and after the plaintiff had made numerous visits to the defendant's office with an increasingly severe limp, the defendant stated that arthritis had developed and insisted that the leg should be exercised and that the boy should be prevented from forming the habit of favoring his right leg. Despite several requests by the plaintiff's father, no x-rays were taken. The result of the injury and this treatment was that the plaintiff's right leg became an inch shorter than his left leg and he suffered a permanent loss of motion in his right hip.

After the defendant's services were terminated

and ten months after the accident, an x-ray of the plaintiff's hip disclosed that he was suffering from a separation of the femoral epiphysis. Attempts were made to reduce the separation and the hip and leg were placed in a cast. But this treatment was unavailing.

At the trial of the malpractice action which the plaintiff subsequently brought, charging negligence in diagnosis and treatment, expert testimony was given to the effect that an osteopathic physician who possesses the ordinary skill and knowledge of similar practitioners in the community in which the defendant practiced, would, under the circumstances, have had an x-ray taken of plaintiff's injured hip soon after the plaintiff first developed the limp and complained of pain in his hip. The defendant attempted to prove that the epiphyseal separation resulted from the glandular disturbance for which he had been treating the plaintiff, but the Court chose to believe the testimony of plaintiff's experts to the effect that premature weight bearing and the defendant's failure to immobilize the hip had caused the separation. The failure to use x-ray in diagnosing the injury was held to constitute negligence and a judgment was rendered against the defendant.

This is not the first time in California that a malpractice action has been prosecuted successfully against a physician for his failure to use x-ray in diagnosing injuries of the type involved in the *Burford* case. The facts of this case bear a striking similarity to the case of *Rankin v. Mills*, 207 Cal. 438. There the defendant physician had also neglected to have x-rays taken of an injured hip and he was held responsible for his improper diagnosis and treatment.

These two cases would seem clearly to establish the proposition that if a physician fails to have x-rays taken of any type of bone injury, and thereby fails properly to diagnose and treat the injury, he will be held for any damages which could have been avoided if an x-ray had been taken and a proper treatment prescribed on the basis of what the x-ray would disclose. This proposition seems inherently reasonable in view of the accessibility of most communities to x-ray apparatus. There is very little that can be said in defense of failure to utilize modern methods of diagnosis when they are accessible.

Slowly we are beginning to realize the relationship between good housing and health. Other agencies have taken the leadership in slum clearance and in the provision of good housing. It is not too late even now, because of the magnitude of the undertaking and the need from the health point of view, for health departments to concern themselves more actively with this subject.—John L. Rice, M. D., *Commissioner of Health, New York City*.

A man will talk much of his experience, and make the same mistake every day.

Simplicity and clearness are the eloquence of science.—*Macaulay*.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

LETTERS†

Concerning Status of Privileged Communications in Relation to Representatives of the Armed Forces

(COPY)

August 27, 1942.

L. A. Alesen, M.D.,
Secretary, Los Angeles County Medical Association,
Los Angeles, California.

Dear Doctor:

Dr. Kress has forwarded to me your letter of August 24, 1942, and enclosures concerning an inquiry by a member of the Association who has been requested by Naval Intelligence to disclose information received by him from a patient in confidence.

From the correspondence, it is my understanding that the patient admitted to the physician that he had falsely represented his physical condition to the Navy in order to avoid Naval service. Of course, the question presented is whether or not the privileged nature of communications between physician and patient exists under the circumstances above set forth.

If the communication concerned service under the Selective Training and Service Act of 1940, then the physician would undoubtedly be under a duty to disclose the information received from his patient to the proper authorities. (*U. S. Code, Title 50, Sec. 311.*) A reason for this is that any assistance given to a person to enable him to evade military service is a criminal act.

Aside from the Selective Service Act, the privilege that the law accords to communications between physician and patient is limited to the extent that any communication made in furtherance of a criminal purpose is not privileged. (*70 Corpus Juris, 445.*) Under the circumstances set forth in your letter, it would appear that the patient obtained dismissal from the Navy on a falsified claim of illness. If this is so, the subject matter of the communication does relate to a criminal purpose because obtaining a discharge under false pretences violates the articles of government of the Navy.

Accordingly, under the circumstances set forth in your letter, it is our opinion that the physician is obligated to disclose to Naval Intelligence such information as he has in his possession and that he may not rely upon the "physician-patient privilege."

111 Sutter Street.

Very truly yours,

HARTLEY F. PEART.

Concerning Hearing re: Minimum Wage Board for Professional and General Business Offices*

(COPY)

Los Angeles, August 14, 1942.

To the Editor.—I understand that the enclosed notice will reach you between issues of your State Journal.

As the notice itself will explain, it is of importance to every professional man and I am forwarding it to you in the hope that there may be some other means of broadcasting it to your membership.

Thanking you for your coöperation,

Sincerely yours,

(Signed) DAVID W. McLEAN, D. D. S.

† † †

MINIMUM WAGE BOARD FOR PROFESSIONAL AND GENERAL BUSINESS OFFICES

A Minimum Wage Board has been appointed under

the Division of Industrial Welfare of the State of California, to set up rules and regulations to accompany the Minimum Wage Law in governing the employment of women in professional and general business offices of the State.

The Minimum Wage Board will consist of four employee members and four employer members. Of the employer group, two will be business employers and two, professional. The two professional members will be Mr. Clore Warne, an attorney, representing the non-health service professions, and David W. McLean, D. D. S., of Los Angeles, representing the health service professions.

Similar Minimum Wage Boards have recently set up rules governing the employment of women in the canning and other industries. It is now the turn of the professional and general business office fields.

Among the problems to be considered will undoubtedly be the following:

What skills and efficiency should reasonably be expected of women employees before they rate the minimum wage?

How long does it take to train an employee in the skills required in a dental office? a medical office? an osteopath's office, a chiropractor's? in various types of business offices?

What about overtime in the professional office? the business office? (The law requires that women shall not work more than eight hours per day, though in some industries which deal with perishable commodities, intermittent overtime is permitted.)

What about payment for overtime?

What should be the wage status of the part time employee?

The Public Hearing of the Minimum Wage Board, will be held in the Auditorium of the California State Building, 217 West First St., Los Angeles, on Tuesday, September 15, at 10:30 a.m. At this hearing any who wish may present arguments for either employers or employees.

MEDICAL EPONYM

De Musset Sign

The de Musset sign of aortic regurgitation was described, not by a physician, but by Paul de Musset (1804-1880), brother of the poet, in his *Biographie de Alfred de Musset; sa vie et ses oeuvres* [Biography of Alfred de Musset: His life and his works]. (Paris, 1877). The following translation is from pages 274 and 275:

"The illness so well cared for by Sister Marcelline had left him with a troublesome tendency to affections of the chest. . . . We called the doctors twice during the course of the winter; they bled him too often.

"Whatever they may say, I am convinced that their lancets caused him irreparable harm. At breakfast one morning in March, I noticed that my brother's head was bobbing involuntarily* with each pulse beat. He asked my mother and me why we were looking at him with such a startled air. We told him what we saw, and he said, 'I did not think you could see it; but I will reassure you.'

"He made some sort of pressure on his neck with his index finger and thumb, and in a moment his head stopped marking his pulse. 'You see,' he then said to us, 'that this dreadful illness can be cured by simple and inexpensive means.'

"We were reassured, being ignorant, for we had just observed the first symptom of a grave malady to which he was to succumb fifteen years later."—R. W. B., in *New England Journal of Medicine*, Vol. 226, No. 12.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

* For other comment in this issue, see pages 172 and 209.

NOMINEES FOR CALIFORNIA LEGISLATURE

A tentative list (almost complete at time of this writing), of candidates nominated for California State Senate and Assembly is given below. For other reference in regard thereto, see comments in this issue, on page 171.

California Senate

<i>District Number</i>	<i>Name of Candidate and Residence</i>	<i>Party Nomination</i>
2	Randolph Collier, 551 N. Main St., Eureka. Incumbent.....	(Democrat and Republican)
4	George M. Biggar, Covelo. Incumbent.....	(Democrat and Republican)
6	Charles H. Deuel, 273 E. Sacramento Ave., Chico. Incumbent.....	(Democrat and Republican)
8	Clair Engle, 1010 Jackson St., Red Bluff. District Attorney, Tehama County.....	(Democrat and Republican)
10	William P. Rich, Marysville. Incumbent.....	(Democrat and Republican)
12	Herbert W. Slater, 800 4th St., Santa Rosa. Incumbent.....	(Democrat and Republican)
14	John F. Shelley, 69 Beachmont Dr., San Francisco. Incumbent.....	(Democrat and Republican)
16	Arthur H. Breed, Jr., 1081 Clarendon Crescent, Oakland. Incumbent.....	(Republican)
16	Patrick William McDonough, 870 Longridge Rd., Oakland. Businessman.....	(Democrat)
18	M. G. Del Mutolo, 1731 Glen Una Way, San Jose. Assemblyman.....	(Democrat)
18	Byrl R. Salsman, 2030 Webster St., Palo Alto. Assemblyman.....	(Republican)
20	Bradford S. Crittenden, 145 E. Harding Way, Stockton. Incumbent.....	(Democrat and Republican)
22	Hugh P. Donnelly, 953 Sierra Dr., Turlock. Assemblyman.....	(Democrat and Republican)
26	Jesse M. Mayo, Angels Camp. Incumbent.....	(Democrat and Republican)
28	Charles Brown, Shoshone. Incumbent.....	(Democrat and Republican)
30	Hugh M. Burns, 3307 Huntington Blvd., Fresno. Assemblyman.....	(Democrat and Republican)
32	Frank W. Mixter, 303 E. Palm St., Exeter. Incumbent.....	(Democrat and Republican)
34	Jesse R. Dorsey, 1028 Q St., Bakersfield. Attorney.....	(Democrat and Republican)
36	Ralph E. Swing, California Hotel, San Bernardino. Incumbent.....	(Democrat and Republican)
38	Jack B. Tenney, 3201 W. 77th St., Los Angeles. Assemblyman.....	(Democrat and Republican)
40	Ed Fletcher, 869 Rosecrans Blvd., San Diego. Incumbent.....	(Republican)
40	Charles Calhoun Dail, 5936 Brooklyn Ave., San Diego. Salesman-manager.....	(Democrat)

California Assembly

<i>District Number</i>	<i>Name of Candidate and Residence</i>	<i>Party Nomination</i>
1	Michael J. Burns, 1644 Summer St., Eureka. Incumbent.....	(Democrat and Republican)
3	Lloyd W. Lowrey, Rumsey. Incumbent.....	(Democrat and Republican)
4	Albert M. King, Riverside Dr., Oroville. Attorney.....	(Democrat and Republican)
5	Ernest C. Crowley, Fairfield. Incumbent.....	(Democrat and Republican)
6	Allen G. Thurman, Colfax. Incumbent.....	(Democrat and Republican)
7	Richard H. McCollister, 77 Marguerite Ave., Mill Valley. Incumbent.....	(Democrat and Republican)
8	Chester F. Gannon, 3543 H St., Sacramento. Attorney.....	(Democrat and Republican)
9	Earl D. Desmond, 2022 22nd St., Sacramento. Incumbent.....	(Democrat and Republican)
11	Charles M. Weber, 219 N. Sutter St., Stockton. Incumbent.....	(Democrat and Republican)
12	James E. Thorp, Lockeford. Incumbent.....	(Democrat and Republican)
13	Francis Dunn, Jr., 1634 69th Ave., Oakland.....	(Democrat)
13	George J. Dugan, Jr., 2000 94th Ave., Oakland. Realtor.....	(Republican)
14	Randal F. Dickey, 3221 Thompson Ave., Alameda. Incumbent.....	(Republican)
14	Frank F. Burke, 2437 Roosevelt Dr., Alameda. Business Executive.....	(Democrat)
15	Bernard A. Sheridan, 3135 Sheffield Ave., Oakland. Incumbent.....	(Democrat and Republican)
16	Arthur W. Carlson, 12 Marlborough Ct., Piedmont. Incumbent.....	(Democrat and Republican)
18	Gardiner Johnson, 765 San Luis Rd., Berkeley. Incumbent.....	(Democrat and Republican)
19	Bernard R. Brady, 886 39th Ave., San Francisco. Accountant.....	(Democrat and Republican)
20	Thomas A. Maloney, 350 Missouri St., San Francisco. Incumbent.....	(Democrat and Republican)
21	Albert C. Wollenberg, 2748 Steiner St., San Francisco. Incumbent.....	(Democrat and Republican)
22	George D. Collins, Jr., 1456 Union St., San Francisco. Incumbent.....	(Democrat and Republican)
23	William Clifton Berry, 3747 20th St., San Francisco. Machinist.....	(Democrat and Republican)
24	Edward F. O'Day, 1353 Church St., San Francisco. Incumbent.....	(Democrat)
24	Ray McAfee, 532 Judson Ave., San Francisco. Public School Teacher.....	(Republican)
25	Gerald P. Haggerty, 155 St. Elmo Way, San Francisco. Insurance Broker.....	(Democrat and Republican)
26	Edward M. Gaffney, 2081 15th St., San Francisco. Incumbent.....	(Democrat and Republican)
27	Harrison W. Call, Eaton Dr., Redwood City. Incumbent.....	(Democrat and Republican)
29	John F. Thompson, Rt. 4, Box 299, San Jose. Farmer.....	(Democrat and Republican)
31	George A. Clarke, Le Grand. Incumbent.....	(Democrat and Republican)
32	Jacob M. Leonard, 470 Hawkins St., Hollister. Incumbent.....	(Democrat and Republican)
33	Fred Weybret, Arroyo Seco. Incumbent.....	(Democrat and Republican)
34	J. G. Crichton, 752 Buckingham Way, Fresno.....	(Democrat and Republican)
35	S. L. Heisinger, Rt. 4, Box 90E, Fresno. Incumbent.....	(Democrat and Republican)
37	Alfred W. Robertson, 1524 Garden St., Santa Barbara.....	(Democrat and Republican)
38	Walter J. Fourt, 315 Lupin Way, Ventura. Attorney.....	(Democrat and Republican)
39	Thomas H. Werdel, 2200 Pine St., Bakersfield. Attorney.....	(Democrat and Republican)
40	Ella Maude Milton, 1329 Pennsylvania Ave., Los Angeles.....	(Republican)
40	Wm. H. Rosenthal, 409 S. Boyle Ave., Los Angeles. Deputy City Attorney.....	(Democrat)
41	Julian Beck, 423 Hagar St., San Fernando. Attorney and Teacher.....	(Democrat and Republican)

<i>District Number</i>	<i>Name of Candidate and Residence</i>	<i>Party Nomination</i>
42	Everett G. Burkhalter, 11005 Morrison St., No. Hollywood. Incumbent.....	(Democrat and Republican)
43	C. Don Field, 1552 Ridgeway Dr., Glendale. Incumbent.....	(Republican)
43	Patrick Henry Ford, 933 Cumberland Rd., Glendale. Attorney.....	(Democrat)
44	John B. Pelletier, 248 S. Olive St., Los Angeles. Incumbent.....	(Democrat)
44	G. Harvey Mydland, 426 S. Hill St., Los Angeles. Property Management.....	(Republican)
45	Thomas J. Doyle, 4333 Griffin Ave., Los Angeles. Incumbent.....	(Democrat and Republican)
47	Charles H. Kelley, 1039 Sinaloa Ave., Pasadena.....	(Democrat)
47	Willis Sargent, 300 Bellfontaine, Pasadena. Lawyer.....	(Republican)
48	T. Fenton Knight, 4850 Oakwood Ave., La Canada. Incumbent.....	(Republican)
48	Virginia Timberlake Steinberger, 501 Mariposa Ave., Sierra Madre.....	(Democrat)
49	Lee T. Bashore, 250 Live Oak, Glendora. Incumbent.....	(Democrat and Republican)
50	Thomas M. Erwin, 1425 S. Central Ave., El Monte. Farmer.....	(Republican)
50	Dailey S. Stafford, 242 E. Center St., Covina. Attorney.....	(Democrat)
51	Elwyn S. Bennett, 918 S. Fraser Ave., Los Angeles. Attorney.....	(Democrat)
51	Francis J. Quigley, 6172 Fairfield St., Los Angeles. Lawyer.....	(Republican)
52	William H. Poole, 4817 Back Ave., Bell. Incumbent.....	(Democrat)
52	Jonathan J. Hollibaugh, 6908 Rugby Ave., Huntington Park. Councilman.....	(Republican)
53	Lothrop Smith, 568 N. Milton Dr., San Gabriel. Attorney.....	(Republican)
53	Hugo A. Norin, 717 Lindaraxa Pk., Alhambra. City Commissioner.....	(Democrat)
54	John B. Knight, 5224 Maywood, Eagle Rock. Incumbent.....	(Democrat and Republican)
55	Vernon Kilpatrick, 1246 S. Hope St., Los Angeles. Incumbent.....	(Democrat and Republican)
56	Ernest E. Debs, 2324 Teviot St., Los Angeles. Tax Statistician.....	(Democrat)
56	Kay Cunningham, 4327 Melbourne Ave., Los Angeles.....	(Republican)
57	Franklin J. Potter, 3277 Primera Ave., Hollywood. Incumbent.....	(Democrat and Republican)
58	Frank J. Waters, 959 Keniston Ave., Los Angeles. Incumbent.....	(Democrat and Republican)
59	Charles W. Lyon, 605 N. Oakhurst Dr., Beverly Hills. Incumbent.....	(Democrat and Republican)
60	Jesse Randolph Kellems, 454 Cuesta Way, Bel Air, Los Angeles. Incumbent.....	(Democrat and Republican)
61	Lester A. McMillan, 2726 Forrester Dr., Los Angeles. Attorney.....	(Democrat)
62	Augustus F. Hawkins, 220 E. 46th St., Los Angeles. Incumbent.....	(Democrat and Republican)
63	Don A. Allen, 3867 Degnan Blvd., Los Angeles. Incumbent.....	(Democrat and Republican)
64	John C. Lyons, 3208 Bellevue Ave., Los Angeles. Business Representative.....	(Republican)
64	Samuel William Yorty, 2575 W. 5th St., Los Angeles. Attorney.....	(Democrat)
65	John W. Evans, 4813 S. Western Ave., Los Angeles. Incumbent.....	(Democrat and Republican)
66	Edward D. McCoy, 1412½ W. 81st St., Los Angeles. Attorney.....	(Republican)
66	Jack Massion, 846 E. 77th St., Los Angeles. Incumbent.....	(Democrat)
67	Adele Arbo, 1412 W. 93rd St., Los Angeles. Vocational Advisor.....	(Republican)
67	Clayton A. Dills, 15145 S. Vermont, Gardena. Service Station Operator.....	(Democrat)
68	Vincent Thomas, 722 W. 20th St., San Pedro. Incumbent.....	(Democrat and Republican)
69	Ralph C. Dills, 1505 N. Spring St., Compton. Incumbent.....	(Democrat and Republican)
70	Lorne D. Middough, 233 Roswell Ave., Long Beach. Incumbent.....	(Democrat and Republican)
71	Fred N. Howser, 3940 Linden Ave., Long Beach. Incumbent.....	(Republican)
71	Arthur A. Allen, 669 E. Seaside Blvd., Long Beach. Deputy City Manager.....	(Democrat)
72	Eugene N. Nisbet, 200 E. 13th St., Upland.....	(Democrat)
72	R. Fred Price, 303 W. Emporia Ave., Ontario. Investments.....	(Republican)
74	Clyde A. Watson, 273 N. Harwood St., Orange. Incumbent.....	(Democrat and Republican)
75	Sam L. Collins, N. Cypress Ave., Fullerton. Incumbent.....	(Democrat and Republican)
76	Nelson S. Dilworth, Rt. 1, Box 18, Hemet. Incumbent.....	(Democrat and Republican)
77	Harvey E. Hastain, 277 W. K St., Brawley. Incumbent.....	(Democrat and Republican)
78	Mary L. Fay, 211 W. Walnut, San Diego.....	(Democrat)
79	Kathryn T. Niehouse, 4889 Bancroft St., San Diego.....	(Republican)
79	Paul A. Richie, 4264 Menlo Ave., San Diego. Incumbent.....	(Democrat)
80	Charles W. Stream, 664 Del Mar Ave., Chula Vista. Incumbent.....	(Democrat and Republican)

MEDICAL EPONYM

Islands of Langerhans

These structures are described in an inaugural dissertation submitted in candidacy for the degree of Doctor of Medicine from the Friedrich Wilhelm's University at Berlin on February 18, 1869, by Paul Langerhans (1849-1888), entitled "Beiträge zur mikroskopischen Anatomie der Bauchspeicheldrüse [Contributions to the Microscopic Anatomy of the Pancreas]." This monograph was privately printed by Gustav Lange, of Berlin, in 1869. A portion of the translation follows:

"These cells are small and irregularly polygonal in form; their contents are quite homogeneous, glistening and without granules; the nuclei are clear, round and of medium size. Their average diameter is from 0.0096 to 0.0120 mm., and that of the nuclei from 0.0075 to 0.0080.

"These cells for the most part lie in clumps, peculiarly distributed in the parenchyma of the gland. If a pancreas that has been in Müller's liquid for two or three days is examined under low power, such as No. 4 objective in Hartnack's system, there will be observed regularly scattered in the gland rounded spots stained a deep yellow, about one to a field when a No. 3 ocular is used. Under higher powers, it is evident that these spots consist entirely of our cells. They are heaped up in rounded clumps, regularly distributed in the parenchyma (in the old meaning of the word) of the gland. The clumps have for the most part a diameter of 0.10 to 0.24 mm., and can easily be perceived even in teased preparations made either from fresh glands or from those that have been treated for a short time with iodine serum."—R. W. B., in *New England Journal of Medicine*.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 9, September, 1917

EXCERPTS FROM EDITORIAL NOTES

The Quota of Doctors for the Army.—There are about 150,000 physicians listed in medical directories. Deducting from these 50,000 who are not in practice, or are physically incompetent, leaves 100,000 doctors available. Of this number the Surgeon-General requires 20,000, or one-fifth of the active practitioners as officers in the Medical Reserve Corps of the army. [In September, 1917.] This means that one out of every five physicians in California is needed in the Army and *must go at once*. Every reader of this page is urged most seriously to see that the profession in his vicinity is represented at least in proportion. . . .

The need of doctors is not alone for the mobile army, but also in concentration camps, evacuation hospitals, base hospitals and on transports. It is of decided advantage to volunteer your services, and receive the benefit of the very necessary training accorded physicians in medical training camps. It is a safe assumption that for those who receive such training and show their aptitude for the service, advancement will be rapid.

Danger from Botulism.—In this present national crisis one of the chief topics of interest to the average citizen has been the rapidity with which staple articles of diet have risen in price until they are almost beyond the reach of the small wage earner. In order to combat the "high cost of living" and to conserve such foods as can be shipped to our allies in Europe, there has been a widely advertised propaganda, urging that all who have access to the fresh material should provide for the coming winter by canning vegetables and fruits at home; and the leading newspapers have cooperated with the authorities by publishing detailed descriptions of how the canning process should be carried out.

It is probable that much larger quantities of fruits and vegetables are being canned at home this year than ever before, and that many persons will be depending upon home-canned foods who have formerly used only commercially-canned products. It is urgent, therefore, that the medical profession should be alert to the danger which may arise from poisoning from foods which have been improperly preserved.

One of the most important types of food poisoning in California in recent years is due to the toxin of the *Bacillus botulinus*, which, as has been shown by Dickson, may be produced in home-canned vegetables and fruits. . . .

Red Cross Units.—Last month attention was called to the opportunity afforded by the Red Cross for physicians at home, as well as for those able with better fortune to serve with the fighting forces of the nation. For the purpose of service with the army, or for purposes of training personnel, there are various Red Cross units available in which a man of any capability, or of any inclination or special training, can find valuable and useful employment. . . .

Editorial Comment.—We have thus far received no

(Continued in Back Advertising Section, Page 24)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.

Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held in the Elks Club, Los Angeles, July 27 to 30, 1942, inclusive.

Approximately 124 applicants, including all classes excepting midwives, wrote the examination. Among the list were several graduates of foreign medical schools, who wrote the examination for physician's and surgeon's certificate.

The following changes in status were made by the Board:

Gerber, Rudolph H. (Naturopath) License revoked July 30, 1942;

Harris, Frederic Douglas, M.D. License revoked July 29, 1942;

Hendley, Charles, M.D. License revoked July 29, 1942;

MacRae, Herbert Bennett, M.D. On July 29, 1942, found guilty of the charges preferred in the complaint and the imposition of penalty was deferred to the October, 1942, meeting in Sacramento;

Miller, Joseph E., M.D. Found guilty at the prior San Francisco meeting of charges as set forth in the complaint and on July 28, 1942, was placed on five years probation, without narcotic privileges or possession;

Rinker, Casper L. A., M.D. License revoked July 28, 1942;

Schneider, Theodore, M.D. Found guilty on two charges and license revoked July 30, 1942;

Wright, George Ainsley, M.D. Found guilty on two charges and license revoked July 29, 1942.

The following licenses, heretofore revoked, were restored:

Duchain, Marie E. (midwife). Restored July 27, 1942, and placed on probation for a period of five years—to report at each summer meeting in Los Angeles;

Kaufman, Morris P., M.D. (revoked Oct. 28, 1938); license restored July 27, 1942, and he was placed on probation for a period of five years without narcotic privileges or possession.

News

"The finding by the Federal Trade Commission of false advertising claims made in medical journals by the John J. Fulton Company of San Francisco concerning its product 'urvursin,' was upheld yesterday by the Circuit Court of Appeals. The commission had ordered the company to desist from advertising the product as a treatment for diabetes, after finding it, according to the opinion of Judge William Healy, 'largely a compound of herbs long enjoying a reputation, particularly in folklore medicine, for the treatment of urinary conditions,' but 'illusory' in its effect on diabetes cases." (San Francisco Recorder, July 22, 1942.)

The Los Angeles Journal of July 9, 1942, under Articles of Incorporation, related that the Chiropractic College of America, City of Los Angeles, has filed a certificate of amended copy, changing its name to the California College of Natural Healing Arts.

(Continued in Back Advertising Section, Page 32)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

For the head-cold patient who won't go to bed



Every practitioner has them — patients who are coming down with colds, but who refuse to go to bed.

While Benzedrine Inhaler cannot be expected to cure these difficult patients, its use will give them marked comfort. Its vapor, diffusing throughout the upper respiratory tract, rapidly relieves congestion and thus promotes ventilation and drainage.

And there is none of the inconvenience of atomizers, droppers and tampons.

Benzedrine Inhaler

A volatile vasoconstrictor

Each tube is packed with amphetamine, S.K.F., 325 mg.; oil of lavender, 97 mg.; menthol, 32 mg. Benzedrine is S.K.F.'s trademark, Reg. U. S. Pat. Off.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

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Fifth Avenue
SAN FRANCISCO,
CALIFORNIA



A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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Las Encinas Sanitarium . . . Pasadena, California

INTERNAL MEDICINE INCLUDING FUNCTIONAL AND ORGANIC NERVOUS SYSTEM DISEASES

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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Text Page 226)

answer to the query last month under the caption, "Medical Women and the War," as to why women physicians should not receive the same rank and emolument for war service as men receive. In case the Government is unable or unwilling to utilize the proffered services of women physicians, the opportunity is not to be forgotten that presents itself in dispensary practice, laboratory, teaching, and various other public activities where men are released, or may be released, for active duty at the front, if only women can be secured to fill their positions. The same process is working out advantageously in other lines. Why should not the woman physician make possible a larger number of medical men with the fighting forces, by taking over their medical services at home?

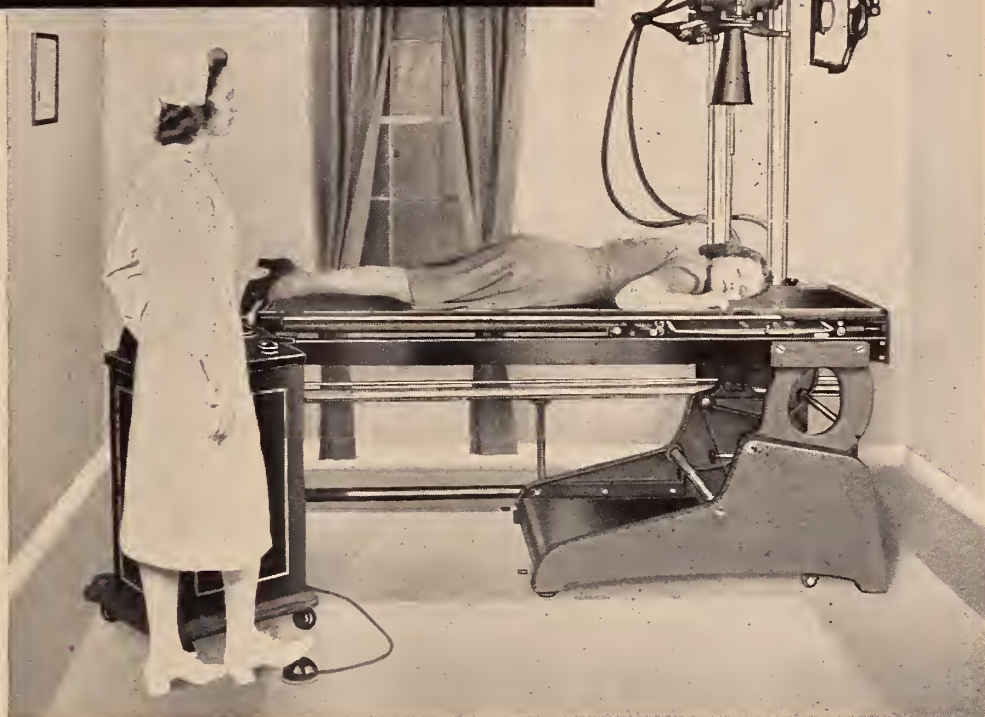
EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Splenectomy in Pernicious Anemia," by Harry M. Sherman, M.D., F.A.C.S., San Francisco.—"The removal of a spleen damaged by rupture, torsion of its pedicle, or loosened from its position in the abdominal cavity, is an operation in itself not difficult and unlikely to lead to any untoward consequences" (Thursfield and Gow). Therefore the spleen itself may be assumed to be an organ not wholly essential to the life of the individual, and "that its functions, whatever these may be, are capable of performance by other tissues in the body." Sir John Bland-Sutton, in the British Journal of Surgery, Vol. I, No. 2, published in October, 1913, quotes Pliny (A. D. 23-79) as saying of the spleen that "sometimes it is a peculiar hindrance to runners, so that they burn it away from those runners who are in-

(Continued on Page 26)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

For Better Radiographic Results, With More Savings in Office Space Investigate the G-E Model R-38



YOU will enjoy many extra radiographic benefits for every dollar invested in the sensibly priced G-E Model R-38 X-Ray Unit. It brings you 100-milliamperere, big-apparatus quality and flexibility—in an area you may have thought far too small to accommodate a combination unit.

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If you want x-ray's benefits but until now have done without them because a combination unit seems too large both physically and as an in-

vestment, investigate the R-38. Clip, fill in, and mail the coupon today for complete and really free information.

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19

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SPECIALIZED
SERVICE

In addition to our Professional Liability
Policy for private practice, we issue a special
MILITARY POLICY
to the profession in the Armed Forces at a
Reduced Premium

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

TWENTY-FIVE YEARS AGO

(Continued from Page 24)

commended by it," and points out that the traditions before the Christian era showed that men and animals could live without a spleen. . . .

From an Article on "Disability from Injury to the Feet," by G. J. McChesney, M.D., San Francisco.—As one of the Medical Referees for the Industrial Accident Commission, I have examined twelve men who have claimed disability from injuries to the feet.

They have exhibited in all sixteen fractures, as follows: Six of one or both malleoli, four of the astragalus, two each of the os calcis and cuneiform, one each of the scaphoid and fifth metatarsal.

Now, this may not seem a series long enough upon which to base any conclusions, but they have been quite instructive to me, and I hope to make them a little so to you.

Their ages varied from twenty-eight to seventy-one, the average being forty-two—men therefore in the prime of life.

The examination was made on an average of eight months after the injury, surely time enough to get a fair estimate of the end results, and these end results were uniformly worse than they should have been. . . .

From an Article on "The Therapeutic Application of Hypertonic Salt-Solution in Conjunction with Leucocytic Extract," by R. A. Archibald and Gertrude Moore, Oakland, California. (From the research department of the Western Laboratories, Oakland, California.)—The ques-

(Continued on Page 28)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

Colfax School for the Tuberculous

COLFAX, CALIFORNIA

► There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
2. Education as to essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
4. Every proved method of treatment, including pneumothorax and phrenic nerve interruption. (Major thoracic surgery referred to skilled thoracic surgeons.)
5. An absence of institutional atmosphere.
6. Reasonable rates.

* * *

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write

ROBERT A. PEERS, M.D.

Medical Director
COLFAX, CALIFORNIA

* * *

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EMILE HOLMAN, M.D.
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SAFE, CONVENIENT, when mother and baby must travel

The mother has only to measure out and place in dry, sterile feeding bottles, the prescribed amount of Similac powder for each individual feeding. The bottles containing the measured Similac powder are then capped, and can be conveniently carried, along with a thermos bottle of boiled water cooled to about blood heat. At feeding time it is necessary only to pour into one of the bottles containing the measured Similac powder, the prescribed amount of water, then shake until the Similac is dissolved, place a nipple on the bottle, and feed.



A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and cod liver concentrate.

SIMILAC

Similar to breast milk

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To the eyes of America has fallen the biggest job they've ever been assigned. You owe it to your country to provide best vision possible to the most people possible. Your professional experience enables you to make skillful refractions. Our job is filling your prescriptions, promptly, precisely. For that purpose we employ trained technicians, who work on modern precision equipment, and use top-quality Bausch & Lomb products.



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Sisters of Mercy

Accredited by the American Medical Association and Approved by the American College of Surgeons. Open to all members of the California Medical Association. Accredited School of Nursing and Out-Patient Department.

TWENTY-FIVE YEARS AGO

(Continued from Page 26)

tion of the relative therapeutic values of leucocytic extract (Archibald) introduced subcutaneously, and that introduced intravenously, alone or in conjunction with various hypertonic salt solutions with special reference to its application in the treatment of cases of infections of the blood stream, was first called to our attention by a case of streptococcemia in which a two per cent magnesium sulphate solution was administered according to the technique of Harrer, together with leucocytic extract which was given as usual subcutaneously. The beneficial effects of this combination were quite marked. . . .

From an Article on "Aneurysm," by Charles D. Lockwood, M. D., Pasadena.—I have decided to present to the Surgical Society tonight the subject of Aneurysm, more especially the class of aneurysms which comes within the scope of surgical treatment. Although the individual surgeon sees but few aneurysms in the routine of his practice, nevertheless, in the aggregate the number of cases is large. When invited by the program committee to appear before you tonight, I attempted, in the brief time at my disposal, to review the articles appearing in the magazines which I regularly read, viz., the Journal of the American Medical Association, Gynecology and Obstetrics and the Annals of Surgery. I found reference to about 200 articles upon this subject during the past three years. Of these, I selected about fifteen representative articles, covering almost every phase of the subject, and upon these is based much of what I shall have to say tonight. . . .



*"has practically remade
the lives of some
epileptic patients."¹*

Dilantin Sodium, an anticonvulsant with relatively little hypnotic effect, has become firmly and deservedly entrenched in the treatment of epilepsy. It is the "drug of choice"² for most patients subject to seizures, especially effective for controlling psychomotor attacks which are little influenced by bromides or phenobarbital.¹

Kapseals Dilantin* Sodium (phenytoin sodium) have indeed opened the way to a new life for many epileptics . . . a more normal and happier life . . . with seizures usually decreasing in number and severity, and sometimes ceasing entirely.

*TRADE MARK REG. U. S. PAT. OFF.

1. McEachern, D.: *Canadian Med. Ass'n. J.*, 45:106, 1941.

2. Lennox, W. G.: *Med. Ann. Dist. Col.*, 10:461, 1941.

Detailed literature upon request.

KAPSEALS DILANTIN SODIUM

*A product of modern research offered to the
medical profession by*

PARKE, DAVIS & COMPANY
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Several phases of a grand mal epileptic seizure schematically pictured in the rare book, "Les Demoniques Dans L'Art," by J. M. Charcot and Paul Richer, published in 1887.





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FOR DISEASES OF THE CHEST

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A small select sanatorium for the treatment of Tuberculosis and other chest diseases.

Each patient receives individual study and care. The referring physician re-

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Climate is ideal. Located at 1,000 ft. elevation, 6 miles east of San Jose, overlooking the Santa Clara Valley. A folder will be sent on request.

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MANAGER

PARK SANITARIUM 1500 PAGE ST.
SAN FRANCISCO.

TWENTY-FIVE YEARS AGO

(Continued from Page 28)



The McKenzie School of Individual Instruction

A non-profit, co-educational resident and day school conducted in a homelike environment on a large orchard estate at Los Altos, in the beautiful Santa Clara Valley of Northern California.

The McKenzie School is the only one West of the Mississippi equipped to educate privately children with impaired hearing.

Direction is by Lilla B. McKenzie, graduate of Central Institute for the Deaf, St. Louis; Studied Science of Speech, Acoustics and related subjects under Louis C. Elson, E. K. Klare, B. Cutter and Charles Kidder, Boston. School is staffed especially to develop each child according to his own abilities.

For information, rules, regulations, rates and references, address:

The McKenzie School

Rincon Annex P. O. Box 3475 San Francisco, Calif.

From an Article on "Uterine Fibromyomata, Their Causation, Prevention and Conservative Treatment. A Record of Individual Experience," by W. A. Briggs, M.D., Sacramento.—Twenty-five or more years ago I attended for Dr. G. G. Tyrrell, during his illness, a woman in labor, in the fundus of whose uterus I found a fibroid three and a half or four inches in diameter, the existence of which was later verified by Dr. Tyrrell himself. The lying-in and lactation were superficially uneventful, but six months later, on examination, Dr. Tyrrell, to his surprise—being a surgeon as well as an obstetrician—perhaps also to his chagrin, could find no trace of the tumor whatever. It had been wholly and spontaneously absorbed. This observation remained latent in my memory until some years afterward when mammary extract was proposed, by Dr. Bell I believe, as a remedy for uterine fibroids, and the absorption of the fibroid during lactation period at once recurred to me and afforded a basis of credibility for the proposed treatment. . . .

From an Article "Upon the Modern Treatment of Bladder-Tumors," by Martin Krotoszyner, M.D., San Francisco.—The diagnosis and treatment of neoplasms of the bladder has, of late, undergone rapid and radical changes; in fact, the scientific recognition and the rational surgical attack of vesical tumors are accomplishments of the last three decades, during which more substantial progress in that direction was made than during the equal number of centuries preceding that period. . . .

ADRENAL CORTICAL HORMONES ESSENTIAL TO LIFE

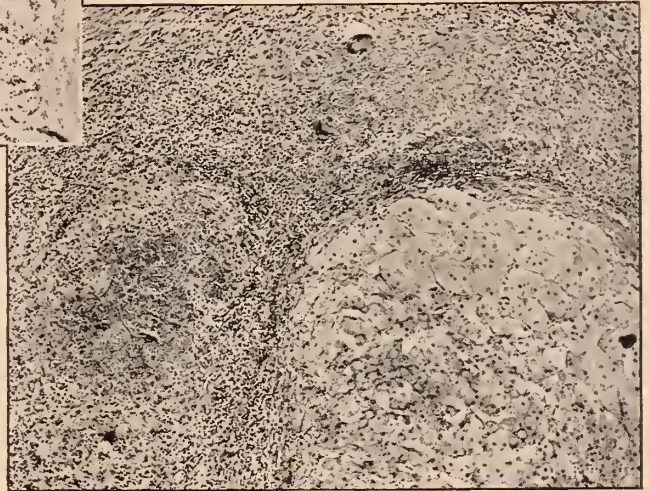


Normal Adrenal Cortex

The cortex of the adrenal gland is essential for life in human beings and in all animals which possess this gland. Its removal is fatal within a few days.

Tuberculosis of the Adrenal

The original description of Addison's disease attributed the condition to tuberculosis of the adrenal. Recent autopsy series show that there may be other causes and that these account for a considerable proportion of the cases.



Sterile Solution Adrenal Cortex Extract (Upjohn)

Sterile Solution Adrenal Cortex Extract (Upjohn) is an extract of adrenal glands from domestic animals, containing the cortical steroids essential for the maintenance of life in adrenalectomized animals, but so purified that only traces, at the most, of epinephrine are present. Each cc. contains not less than 50 dog units of cortical activity (2.5 rat units) when assayed by the method of Cartland and Kuizenga (American Journal of Physiology 117:678, 1936).

Sterile Solution Adrenal Cortex Extract (Upjohn) is of value in cases of Addison's disease or of adrenal cortex insufficiency, and in surgical procedures involving the adrenal gland, such as removal of cortical tumors, as a prophylactic measure to prevent the development of symptoms of adrenal cortex insufficiency.

Sterile Solution Adrenal Cortex Extract (Upjohn) is supplied in 10 cc. size rubber-capped vials as a sterile solution for injection.



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(Continued from Text Page 226)

"Paint by day and pain by night—that, according to state authorities, was the routine for 'Dr.' M. F. Koyle until today when he was arrested and charged with practicing medicine without a license. Special Agent J. W. Williams of the State Board of Medical Examiners, who arrested Koyle, said he was practicing without a license, although he had an Oakland business license as a 'medafod physician.' Daytimes Koyle worked as a painter in an Oakland shipyard; nights he worked as a medafod physician, it was charged. He is 60, lives at 3620 Porter St., Oakland, and is free on \$100 bail." (San Francisco News, July 15, 1942.)

"Asserting that the charges filed against him are insufficient to substantiate a conviction, Dr. A. M. Tweedie, charged with murder and an illegal operation involving the death of a Santa Monica woman, has demurred to the charges in Los Angeles county superior court. The dead woman is Mrs. Leona Gertrude Tarelton, who died in the doctor's offices in suburban Los Angeles early in June. The matter is to be argued tomorrow." (Santa Monica Outlook, July 6, 1942.)

"Mrs. Carmen Cantu, 39, of Santa Ana, recently convicted of performing an illegal operation, must serve six months in jail as a condition of three years probation granted her yesterday by Presiding Judge George K. Scovel in superior court. The Court ordered her to start serving the jail sentence next Monday. . . ." (Santa Ana Register, July 4, 1942.)

(Continued on Page 34)



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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
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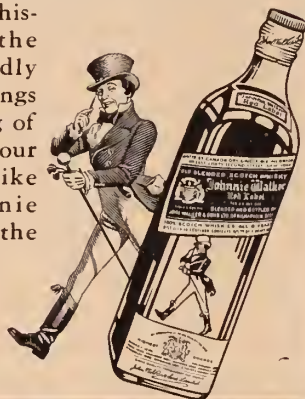
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(Continued from Page 32)

"Suffering from head injuries and severe cuts received in what he told officers was a beating administered before he was forced to write a \$150 check by a taxicab driver and his wife, Dr. Thomas J. Welsh, of Alameda, was in a serious condition in Wheeler Hospital, in Gilroy, today. . . . Dr. Welsh said he had been picked up in Oakland and driven to San Jose and then forced to write a \$150 check. Reports given the sheriff's office and the highway patrol said that Dr. Welsh objected to signing the check, put up a fight, and in his struggles caused the taxicab to wreck near Gilroy. . . ." (San Jose News, Feb. 18, 1942.)

"Dr. William Friedberger, medical superintendent of the San Joaquin General Hospital for the last 30 years, has resigned and his position will be occupied by Dr. H. J. Bolinger of Lodi. . . . The change will be effective August 1. . . ." (Stockton Record, July 10, 1942.)

"Dr. Aaron J. Rosanoff, former Director of State Institutions, yesterday announced he was 'retiring from all political activities.' Dr. Rosanoff said he will return to his private medical practice in Beverly Hills on August 1 and will 'never again enter politics of any kind.' . . . (Los Angeles Times, July 23, 1942.)

"The State Board of Medical Examiners Tuesday convicted Dr. Chester D. Sewall of Redding, on two charges of performing illegal operations, and is conducting a

(Continued on Page 36)

ROPER SURVEY

SHOWS MANY MOTHERS DO NOT REALIZE IMPORTANCE OF PRESCHOOL IMMUNIZATION

SMALLPOX

- only 1/2 of 1% of all mothers say they would have vaccination at proper age of 6 months.
- 22% would wait until children were 6 years old.
- 35% would wait for an epidemic or until child was exposed.

WHOPING COUGH

- 2% realize that they should have their children inoculated between 6 months and a year.
- 53% would wait until exposure or an epidemic.

DIPHTHERIA

- 2% would have children inoculated at age of 1 year.
- 13% would wait until school age.
- 49% would wait until an epidemic appeared or until exposure.

SCARLET FEVER

- 7% would wait until school age.
- 65% until an epidemic appeared or until exposure.

Clearly, the Roper survey reveals that mothers do not appreciate the great importance of having their children immunized in infancy.

Fortunately, many thousands of mothers will immunize their children when advised to do so by their physician.

The increased liability of epidemics in war time is a real concern to many physicians. They know that the mass movements of our population, regardless of possible enemy action, will undoubtedly spread disease.

With the war increasing the strain on medical personnel, it would clearly seem the duty of each physician to immunize his patients so that needless sickness be cut to a minimum.

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2. It provides important information which helps prevent undue reactions if serum therapy is again indicated.

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1. By providing specific immunization information.
2. By reminding patients when to return or bring children to physician for reimmunization.
3. By providing information necessary if patient should change residence and consult another physician.

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Patient's Record

Patient's Immunization Record

Disease	Date (Indicate Time Considered)	Remarks	has been vaccinated against
Smallpox			
Diphtheria			
Scarlet Fever			
Whooping Cough			
Polio			
Measles			
Other			

Physician's Immunization Record

PATIENT'S

Name _____

Address _____

Date of Birth _____

Physician's Name _____

Physician's Address _____

Physician's Phone Number _____

Physician's Record

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(Continued from Page 34)

hearing on a similar charge against Dr. Thomas D. Wyatt, according to press reports from San Francisco. Decision on a penalty in Dr. Sewall's case was deferred until later. . . ." (Anderson News, July 2, 1942.)

"Dr. Charles W. Calvert, shooting air raid warden of Redondo Beach, having paid fines totaling \$100, was on six months' probation today as a result of shooting out a street light in Redondo during an alert on the evening of May 22. Dr. Calvert was found guilty by a jury in Redondo Police Court of malicious mischief, discharge of firearms and intoxication. Judge Collamer A. Bridges assessed the penalty." (Los Angeles Herald and Express, July 28, 1942.)

Influence of 'Sodium Amytal' on Intelligence.—

During air raids on London various sedatives were tried on anxious patients, not only therapeutically, but prophylactically to reduce apprehension and induce a state of relative mental calm. In order to determine the degree of mental impairment and the capacity to react reasonably to an emergency, Slater, et al (Lancet, 1:676, June 6, 1942), measured the effect of 'Sodium Amytal' (Sodium Iso-amyl Ethyl Barbiturate, Lilly) by means of standard intelligence tests which were performed on nearly 400 cases. It was concluded that doses of 3 grains or less did not impair the functioning of the patients' intelligence to any important extent. The drug must be prescribed, nevertheless, with individual susceptibilities and requirements in mind. Doses of 1 grain to 3 grains were most generally useful.

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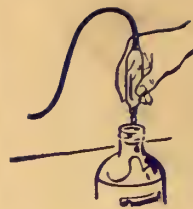
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Will smallpox continue to decline in 1942?

SMALLPOX VACCINE

Lederle

THE new "low" in smallpox incidence reached in this country in 1941 compares most favorably with the perennially high incidence reported in previous years:¹

	Median
1941	1936-40
SMALLPOX 1,368	9,574

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To avert the possible increase in the incidence of infectious diseases, which history has shown is fostered during war time, our government recently made the commendable move of advising the immunization of all children over 6 months of age against smallpox. The success of this program, however, depends on the cooperation of every practitioner, public health official and local governing body alike.

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¹Pub. Health Rep. 57:23,24 (Jan. 2) 1942.

²TOOMEY, J. A.: J. A. M. A. 119:18 (May 2) 1942.



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A. 107:755 (Sept. 5) 1936.

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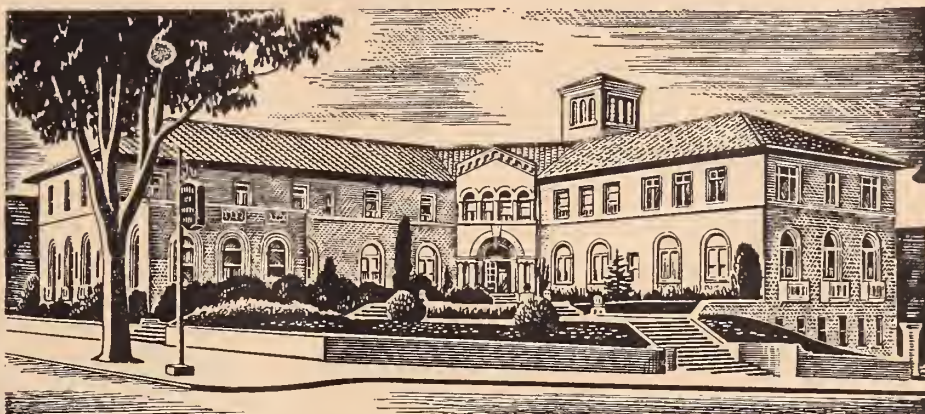
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Civilian Health in Wartime. By Francis R. Dieuaide, M.D., Associate Professor of Medicine, Harvard Medical School, Massachusetts General Hospital. Cloth. Price \$2.50. Pp. 327. Cambridge: Harvard University Press, 1942.

The Pharmacopoeia of the United States of America. Twelfth Revision (U.S.P. XIII). By Authority of the United States Pharmacopoeial Convention. Prepared by the Committee of Revision and Published by the Board of Trustees Official from November 1, 1942. Easton, Pa.: Mack Printing Company.

First-Aid, Surgical and Medical. By Warren H. Cole, M.D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago, and Charles B. Puestow, B.S., M.S., M.D., Ph.D., F.A.C.S., Associate Professor of Surgery, University of Illinois College of Medicine and Graduate School; Surgeon, Illinois Research and Educational Hospitals; Senior Surgeon, Henrotin Hospital; Consulting

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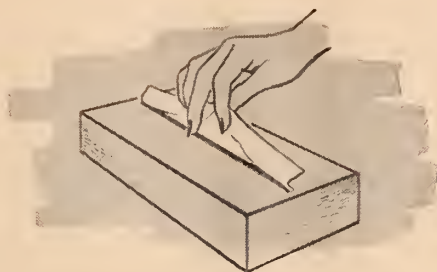
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BOOKS RECEIVED

(Continued from Page 7)

Surgeon, Municipal Contagious Disease Hospital and Bethany Home and Hospital, Chicago, and Saint James Hospital, Chicago Heights. Cloth. 351 pp. Illustrations by Carl Linden in collaboration with Tom Jones of the Illustration Studios of the University of Illinois College of Medicine, Chicago. New York: D. Appleton-Century Company, Incorporated, 1942.

Bonnie's Baby Brother and How He Grew. By Elizabeth Ryder Montgomery. Photographic illustrations by Ralph W. Berry. Foreword by Clara Savage Littledale. Cloth. Price \$2.00. Pp. 95. Philadelphia and New York: Frederick A. Stokes Company, 1942.

Röntgen Treatment of Diseases of the Nervous System. By Cornelius G. Dyke, M.D., F.A.C.R., Associate Professor of Radiology, College of Physicians and Sur-

geons, Columbia University; Director, Department of Radiology, Neurological Institute of New York, and Leo M. Davidoff, M.D., F.A.C.S., Chief, Department of Surgery, Attending Neurological Surgeon, Jewish Hospital of Brooklyn. Cloth. Price \$3.25. 198 pp. with 12 engravings, 7 charts and 16 graphs. Philadelphia: Lea & Febiger, 1942.

Annual Report of the Board of Regents of The Smithsonian Institution. Showing the operations, expenditures, and condition of the Institution for the year ended June 30, 1941. Cloth. Price \$2.00. Pp. 596. Washington, D.C.: United States Government Printing Office, 1942.

Synopsis of Pathology. By W. A. D. Anderson, M.A., M.D., Assistant Professor of Pathology, St. Louis University School of Medicine; Pathologist, St. Mary's Group of Hospitals. Leather. Price \$6.00. Pp. 661 with 294 text, illustrations and 17 color plates. St. Louis: The C. V. Mosby Company, 1942.

(Continued on Page 13)

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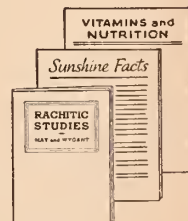
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BOOKS RECEIVED

(Continued from Page 10)

Human Pathology. By Howard T. Karsner, M.D., Professor of Pathology, Western Reserve University, Cleveland, Ohio. Cloth. Price \$10.00. Pp. 817, with 460 illustrations in black and white and 24 subjects in color on 16 plates. Sixth edition, completely revised and reset. Philadelphia: J. B. Lippincott Company, 1942.

Shock: Its Dynamics, Occurrence and Management. By Virgil H. Moon, A.B., M.Sc., M.D., Professor of Pathology, Jefferson Medical College, Philadelphia, Pa. Cloth. \$4.50. 324 pp., illustrated with 36 engravings. Philadelphia: Lea and Febiger, 1942.

BOOK REVIEWS

Administrative Medicine. By Haven Emerson, A.M.,

M.D., Professor Emeritus in Residence, DeLamar Institute of Public Health, College of Physicians and Surgeons, Columbia University. Leather. Price \$10.50. Pp. 839. New York: Thomas Nelson & Sons, 1942.

The writings of Doctor Emerson have given him an established reputation in matters dealing with public health and administrative medicine.

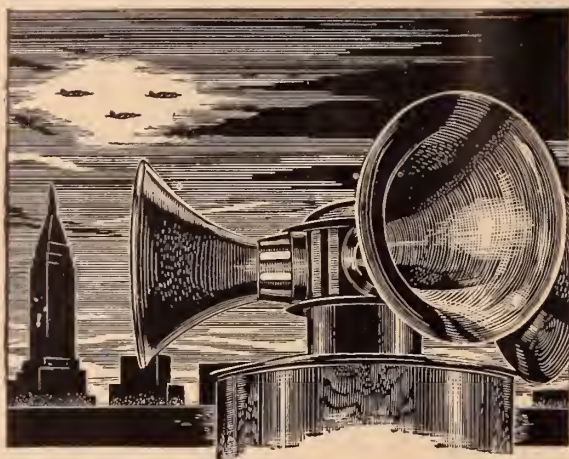
In the present volume, attention is called to the rapid changes which have taken place during the recent decades concerning the relationship between private practice and public-health work.

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(Continued on Page 14)

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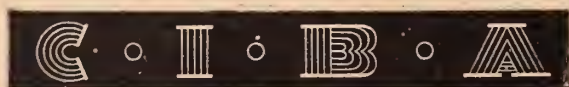
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BOOK REVIEWS

(Continued from Page 13)

to secure as collaborators some of the foremost public-health authorities in the United States.

The book is divided into two major portions: one dealing with the organized care of the sick, and the other with public health. Under the term, *organized care of the sick*, are listed those special functions provided by institutions and agencies generally found in the mature urban society of today and recognized as necessary to meet our ambition for humane, competent and economical care of the sick. Public health is construed to be the application of the sciences of preventive medicine through civil government for social ends. For military needs and under certain conditions of emergency or catastrophe, the health of the civilian population is protected by other than civil government forces.

National governmental proposals of the present federal administration, the admirable inclusive systems of the U. S. Army and Navy, the wholly creditable accomplishment of college and university health services, and a consideration of the economic and sociological aspects of administrative medical schemes are dealt with in sufficient detail.

Doctor Emerson states that the volume is offered in the conviction that benefit—social, professional and personal—will result from a closer familiarity by patients and doctors with the resources of administrative medicine of our day.

The Care of the Aged (Geriatrics). By Malford W. Thewlis, M.D., Attending Specialist, General Medicine, United States Public Health Hospitals, New York City; Attending Physician, South County Hospital, Wakefield, R. I.; Special Consultant, Rhode Island Department of

(Continued on Page 16)

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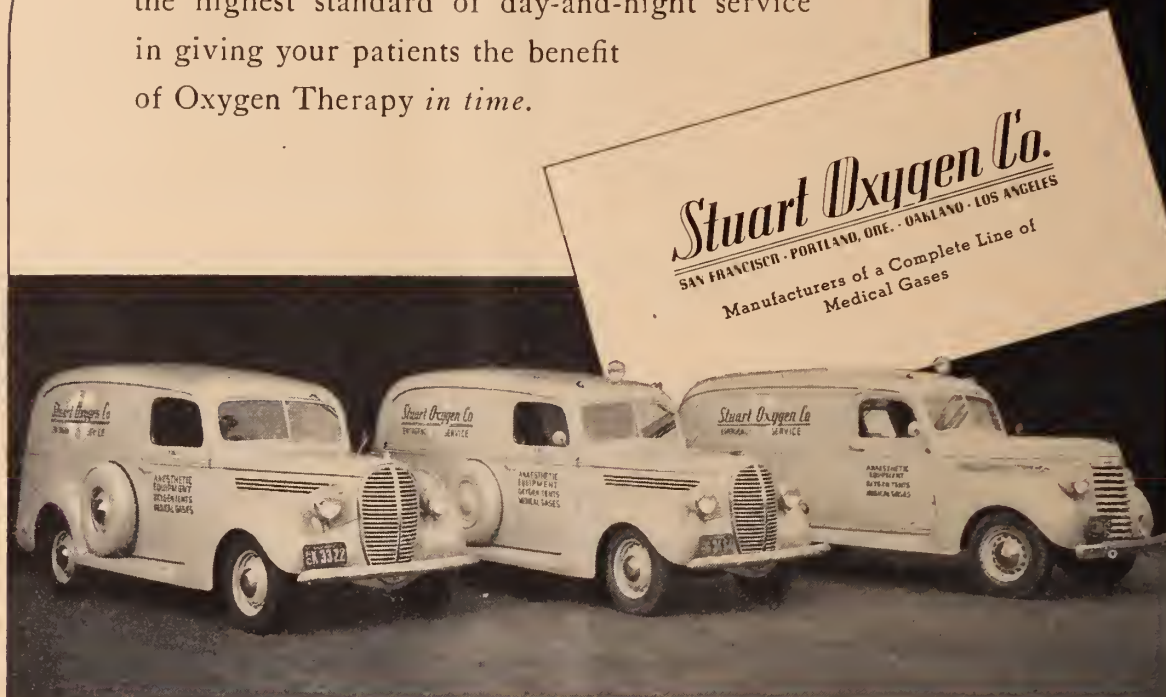
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BOOK REVIEWS

(Continued from Page 14)

Public Health. Fourth Edition. Thoroughly revised with 50 illustrations. Cloth. Price \$7.00. Pp. 589. St. Louis: The C. V. Mosby Company, 1942.

The whole subject of geriatrics is increasing in importance, because of the great shift in our living population. Today there is a much larger proportion of our population alive over 60 than in the last century. Geriatrics, dealing with the problems of advancing years, is becoming a specialty. There is a wider recognition today that the ills of the aged are a special problem: first, because many of them are peculiar to the aged, and second, because the presence even of those which also occur in younger people raises special therapeutic problems in senescence.

This book is divided into five sections. General considerations are taken up in Section I; miscellaneous medical problems in Section II; specific infections in Section III; noninfectious diseases in Section IV; and pathologic conditions in old age in Section V.

Emergency Care. By Marie A. Wooders, B.S., R.N., Principal, School of Nursing, Hackensack Hospital, Hackensack, New Jersey, and Donald A. Curtis, M.D., Lieutenant-Colonel, Medical Reserve, Commanding 342nd Medical Regiment, United States Army; Instructor in Military Nursing, Hackensack Hospital, Hackensack, New Jersey. Cloth. Pp. 560, with 201 illustrations. Philadelphia: F. A. Davis Company, 1942.

The new fields of service that have opened in nursing within the last comparatively few years are all associated in some way with First-Aid and Emergency work, as, for instance, in industrial nursing, school nursing, camp nursing, etc.

As nursing in the Red Cross, the Army, and the

(Continued on Page 17)

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BOOK REVIEWS

(Continued from Page 16)

Navy are branches of the nursing profession, nurses especially should have some knowledge of these departments.

This book should prove of great assistance to civilian nurses in their professional duties, but will also rapidly orient them in the realities of nursing service as modified by the necessities of military service.

Clinics: Symposium on Burns and Shock. (Issued bi-monthly). Vol. 1, No. 1, June, 1942. Edited by George Morris Piersol, M. D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa. Paper. Price \$12.00 per year. Pp. 264. Illustrated. Philadelphia: J. B. Lippincott Company, 1942.

"The Clinics" is a new publication that will appear every two months throughout the year, in place of "The New International Clinics."

As the volume's keynote: timeliness—current reporting—practical, useful articles for a profession which is being called upon to contribute its whole knowledge and experience for the welfare of millions in this crisis.

The June issue includes a symposium on burns and shock.

Physical Diagnosis. By F. Dennette Adams, M. D., Instructor in Medicine, Harvard Medical School, Courses for Graduates, Physician, Massachusetts General Hospital. Thirteenth edition. Cloth. Price \$5.00. Pp. 888, illustrated. Baltimore: Williams & Wilkins Company, 1942.

This well-known volume endeavors to present an account of the diagnostic methods and processes needed by competent practitioners of the present date. It makes no attempt to describe technical processes with which the writer has no personal familiarity, and gives no space

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 17)

to description of tests which he believes to be useless.

In diagnosis, as in therapeutics, "*What do you find valuable?*" is the question that our contemporaries ask of any one of us, not "What has been recommended?"

The Mind and Its Disorders. By James N. Brawner, M. D. Medical Superintendent, Brawner's Sanitarium, Smyrna, Georgia. Cloth. Price \$3.50. Pp. 228. Atlanta: Walter W. Brown Publishing Company, 1942.

This book aims to describe briefly and in language as simple as the subjects permit, the neuroses, psychoneuroses and psychoses. Since mental disturbances are far too numerous for all cases to be treated by the trained psychiatrist, especially in the smaller cities, it is necessary for the general practitioner to meet this problem the best way possible.

The author expresses the opinion that, in the treatment of psychiatric patients, the determination of the causative factors is of far greater importance than the study of the mental symptoms manifested; yet, it is extremely satisfying to be able to comprehend the cerebral mechanisms involved in the production of abnormal mental reactions.

Tuberculosis Hospital and Sanatorium Directory. Compiled by the National Tuberculosis Association, June, 1942.

Since the publication of the last edition of the Directory in 1938 the number of beds for tuberculosis in continental United States has increased from 89,692 to 97,726.

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(Continued in Back Advertising Section, Page 22)

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan., 1937, Vol. XLVII, No. 1, 58-60

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 57

OCTOBER, 1942

NO. 4

California and Western Medicine

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CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco
Phone DOuglas 0062

Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR GEORGE H. KRESS

Committee on Publications

George W. Walker (Chairman) Fresno 1943
F. Burton Jones Vallejo 1944
Francis E. Toomey San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER JOHN HUNTON

Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

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EDITORIALS

BASIC SCIENCE INITIATIVE

Its Fate Will Be Decided on November 3d.

—On Tuesday, November 3d, the voters of California will pass judgment on whether all practitioners of the healing-art shall be required—before being eligible to take licensure examinations—to possess certain fundamental knowledge on subjects termed “basic sciences,” namely, anatomy, physiology, biochemistry, bacteriology and pathology.

The justification of such a law is based on the proposition that the State has a primary obligation to conserve the health and lives of its citizens, and that this governmental function can only be fulfilled in proper manner when practitioners of the healing-art are possessed of adequate education and training. During more than two decades, the California Medical Association has promoted the enactment of a basic science statute, and this year an active campaign was instituted, and the necessary signatures were secured, to place the proposed law before the electorate.

To carry on this educational campaign, however, and to secure the needed signatures, it has been necessary for the California Medical Association to allocate more than fifty thousand dollars from its general funds. This is a large amount of money, but if Proposition No. 3 is enacted, the expenditure will not have been in vain.

It may be said that, by and large, citizens are in favor of adequately-educated healing-art practitioners. The Basic Science law which will appear on the November 3d ballots is not retroactive; that is, it will not apply to healing-art licentiates now on the rosters of their respective examining boards. It does provide that future graduates shall possess this necessary education.

However, the tacit approval by the laity of the principles involved, does not permit the assumption that the measure will go on to easy adoption. On the contrary, owing to the existing unsettled conditions, the vote may not be heavy, and Proposition No. 3—the Basic Science Initiative—can through over-confidence, go down to defeat! Such a happening would be a calamity—in many ways.

* * *

Physicians Must Continue to Work up to November 3d.—Because of the importance of the issues at stake, too much emphasis cannot be placed upon the statement that it behooves California physicians, who are still in civilian practice, to use every possible facility to educate the public to understand that Proposition No. 3 on

the November ballot is worthy of a Yes vote. This coöperation is an obligation due not only to the public health, but also to colleagues who are in service with the armed forces. These fellow physicians in military service have a right to expect us to safeguard both the interests and standards for which they are now offering their all.

We must not be found wanting!

NEXT YEAR'S ANNUAL SESSION OF CALIFORNIA MEDICAL ASSOCIATION WILL BE HELD AT DEL MONTE

A.M.A. Will Not Meet in San Francisco

Action of C.M.A. Council.—The action taken by the California Medical Association, when it was informed that the Board of Trustees of the American Medical Association might deem it expedient not to convene general sessions of its scientific sections in the year 1943, is reported in Item 9 of the minutes of the meeting of the C.M.A. Council held last month, on September 13.

It will be remembered that, two years ago, the A.M.A. House of Delegates voted to hold their annual session in 1943 in San Francisco. To the Council of the California Medical Association, the proposed action by the authorities of the national organization, if taken, therefore meant that the San Francisco and California Medical Associations might not be the hosts at next year's convention. (The minute item referred to and others having relation thereto appear in this issue on the following pages: page 247, C.M.A. minutes; page 249, letter from Secretary West of the A.M.A.)

* * *

A.M.A. Trustees Vote Postponement.—At its meeting held in Chicago on September 17, the A.M.A. Board of Trustees, for reasons indicated in Secretary West's letter of September 22, 1942, voted not to convene the Scientific Assembly (Scientific Sections, Scientific and Technical Exhibits) but to call, instead, only a meeting of the A.M.A. House of Delegates, to be held in Chicago at a date to be announced later.

With this action, under existing circumstances, no serious exception is taken.

* * *

Suggestion to A.M.A. House of Delegates.—However, the suggestion is made, and the wish is expressed, that at its next meeting the A.M.A. House of Delegates will see fit to adopt a resolution, providing that the cities which had been honored as future places of meetings for A.M.A. sessions (San Francisco in 1943, St. Louis in 1944, and New York in 1945) be retained as prospective hosts in the same order, when general sessions are again resumed. Such an arrangement would permit San Francisco to be first as a city so honored, be that in 1944 or another year; the

hope being, too, that conditions may amend themselves to permit a San Francisco session of the A.M.A. in 1944.

* * *

California Medical Association Session in 1943 will be Held.—Item 21 of the C.M.A. Council minutes of the September 13th meeting recites that the California Medical Association will convene its 72nd annual session at Del Monte—probably in May—unless unforeseen complications arise. Action taken:

It was agreed that plans previously outlined for next year's annual session of the California Medical Association, to be held at Del Monte, should be carried through, the C. M. A. Executive Committee or Council being in position to change the same should conditions so warrant.

* * *

Suggestions for Prospective Essayists and Participants in C.M.A. Session.—Members of the C.M.A. who are in civilian practice are requested to make note of the above decision, and physicians throughout the State are urged to look forward to attendance, on at least one or two days of the session. The rail accommodations, either direct or by way of Salinas, are no more inconvenient, for instance, than those met with, in June last, out of Philadelphia to Atlantic City.

This year's session of the California Medical Association at Del Monte is considered to have measured up to best, and for next year's convention, the hotel and meeting room accommodations are ample. The scientific programs, in the light of newer knowledge coming to us through the channels of military and industrial medicine, can be made most valuable to those in attendance; and also to others, who will read the proceedings in the OFFICIAL JOURNAL.

All who are in position to coöperate, through presentation of papers are urged to communicate promptly with the proper section secretary, the names of section officers appearing in every issue of CALIFORNIA AND WESTERN MEDICINE, on advertising page 6.

Appeal is also made to members who may be able to present scientific exhibits. In this issue, a copy of one of the handsome, framed certificates is shown. (See page 261.)

Regarding exhibits and films on medical and surgical subjects, correspondence should be addressed to the Association Secretary.

Concerning the advisability of meetings of State medical societies, it may be in order to quote from a recent letter received from Secretary Olin West of the A.M.A., who states:

"I know of no reason why the meetings of the state medical associations should not be held since no interstate movement of moment will be involved. I hope that your meeting scheduled for Del Monte in May will be a most successful occasion."

Even though the attendance prove not so great as in years gone by, the C.M.A. session scheduled for May of 1943, can be made to be of real interest and greatest value.

Wish not so much to live long as to live well.

—Benjamin Franklin, *Poor Richard*, 1738.

* For additional information concerning the Basic Science law, the following references to recent articles in CALIFORNIA AND WESTERN MEDICINE are given: July, pages 4 and 100; August, pages 117 and 153; September, pages 171 and 208. In this issue, see page 257.

PREPAYMENT MEDICAL SERVICE PLANS: C.P.S.

Achievements of the Physician-Patient Personal Relationship.—Full medical service, with hospitalization, if needed, as given by a physician who is voluntarily chosen by the patient, represents what might be termed the desirable physician-patient relationship, and one which has permitted scientific medicine in the United States to render a service that has been reflected in lower morbidity and mortality rates than can be shown in any other country.

Nevertheless, in spite of the record, the splendid scientific achievements of the profession in recent years have been under attack from a comparatively small but rather voluble group of individuals and organizations—largely outside the medical profession, it is true—who, in exhortation of their theories, do not hesitate to push aside, as of no great importance or worth, the procedures in ethical and scientific practice that have had much to do in lowering the sickness and death rates of the Nation.

The economic set-up that, with the advent of the "mechanical age," came into being during the last half century, brought in its wake a number of social welfare problems that were previously of no very serious import. Thus, the larger number of citizens belonging to the lower income groups who gravitated to the industrial communities threw a steadily mounting burden upon both public and charitably endowed hospitals, in which medical and surgical service was largely donated by physicians. Also, the researches in scientific medicine brought to the front many procedures that can best be carried out in hospitals. In this manner, all classes of the public were rapidly educated concerning the newer healing-art methods as carried on in hospitals. These institutions are now so firmly established that a return to the former conditions is impossible.

* * *

Human Elements Involved in the Problem of Medical Service.—In a discussion of problems concerned with healing-art care of the lower income groups, it is well to keep in mind: the patient group, or patients on the one hand, and the "lay planners" who wish to inaugurate new procedures in medical service on the other; and also in the professional group, one, the physicians, and two, the hospital executives. In these four classes, the patients, as heretofore, wish early recovery. Unfortunately, high pressure salesmanship with its part-time payments burdened a large number of these citizens with unneeded accessories and debts, leaving many of them, in addition, with insufficient funds to properly compensate their physicians for services that had been rendered. In this deplorable state, many of such patients have become willing listeners to the propagandists who were and are promoting state or socialized medicine.

The costs of hospitalization service, with eight-hour personnel shifts, and expense of time-consuming, scientific procedures likewise have been

steadily increasing. Since hospitals, in one sense, are hotels—whose patrons are ill or injured citizens—these institutions have found it necessary to protect themselves from bankruptcy by making the first drafts on the pocketbooks of patients. Too often, after such expenses have been paid, there has been no money remaining with which the attending physicians could be compensated.

The doctors of medicine thus become the victims of a chain of circumstances over which they have little control, and which may become a menace not only to their own economic and social welfare, but also to the profession of which they are members. It is little wonder, therefore, that some physicians should feel restless when called on to underwrite, with either professional services or funds, prepayment plans for medical and hospitalization services designed to serve the lower income groups, for whom theorists have raised insistent demands for "more adequate medical care."

* * *

Long View Essential.—On the other hand, it is important that members of the medical profession should take the long view of these problems and not feel too greatly injured if unit values for professional services, in plans such as California Physicians' Service, do not more rapidly come up to the normal unit.

Nor should such plans, when promoted by organized medicine, too greatly approximate idealistic service. The first attainment should be to place a proposed plan on a self supporting basis; even though, to accomplish that end, limited contracts and other safeguarding provisions are found necessary. After which, as success and larger mass-spread are achieved, it will be possible to approximate full-unit values, build up reserves for epidemics or other unpredictable needs, and also extend the scope of service.

In our own State, California Physicians' Service has been called upon to hurdle many difficult obstacles. That this state-wide plan for medical service has been able to move steadily onward, even though somewhat slowly, is most gratifying. With continuation of the generous coöperation rendered in the past by the professional members, and with patience, even though the same is irksome at times, C.P.S. should be of increasing value to the citizens of California, and become a real bulwark against attempts to thrust state or socialized medicine upon our people.

INDUSTRIAL WARTIME HEALTH: THIS MONTH'S SUPPLEMENT

A Valuable Symposium on Wartime Industrial Health.—In the present issue, CALIFORNIA AND WESTERN MEDICINE presents to its readers the addresses—some in full, others in abstract—which were given during August last at the Institutes on Wartime Industrial Health, held in the cities of San Francisco, Crockett, Oakland, San Diego, Inglewood, Glendale, and Huntington Park. Announcements and other information concerning the programs have already appeared

in the Postgraduate Department in the last two numbers of the OFFICIAL JOURNAL.*

During recent months the medical profession has been giving increasing attention to the many problems in preventive and curative medicine which have been rapidly coming to the front in communities where massive activities in wartime industry are now in operation. The Institutes on Wartime Industrial Health were brought into being through joint action of the Western Association of Industrial Physicians and Surgeons, California State Board of Public Health and the California Medical Association, in an effort to urge physicians, both in industrial and general practice, to take greater interest in some of the newer measures and procedures which industrial establishments have found necessary, through experience, to observe, if the health of employees and the efficiency in their output are to be maintained. It cannot be too often stated that now, since we are at war, every hour lost, through preventable illness or injury of men and women at work in war plants, becomes a factor that must be reckoned with, if the lives of soldiers at the front are to be properly conserved. The articles which appear in this number will permit readers to orient themselves concerning some of the problems which are met with in factories and other industrial workshops.

Mention may also be called to the example of coöperative endeavor in the promotion of the recent Institutes. Each of the three bodies concerned with their presentation gave valuable aid. In due course announcement will be made of other meetings to be held in the near future.

* * *

Proposed "Section on Preventive and Industrial Medicine and Public Health".—In informal table discussions at several of the recent meetings, it was suggested that the C. M. A. Section on Industrial Medicine and Surgery might wish to emulate the example set by the former A. M. A. Section on Industrial Medicine, which extended the scope of its work, taking on a new title, namely, "Section on Preventive and Industrial Medicine and Public Health." Modern-day industrial medicine trenches in large degree into the domain of preventive medicine, as do public health activities. As is well known, in recent years, an increasing number of physicians have been taking up public health as their major, or life-work, and it is important that these colleagues who are in public life shall be adequately recognized and welcomed in organized medicine.

In the Postgraduate Department of the current issue appears the program of the Health Officers Department of the League of California Cities. That program reveals topics which are of interest and importance to all physicians, and also lists the names of many colleagues who have had close affiliation with the California Medical Association. Those ties of understanding and coöperation must be continued—how better, then, than through the proposed extension of work of one of

C. M. A.'s twelve scientific sections? At the annual sessions, it would not be difficult to arrange the programs to give ample opportunity for portrayal of matters of mutual interest.

Members of the C. M. A. Section on Industrial Medicine and Surgery have stated that they will ask their group to request the House of Delegates at the Del Monte meeting in May, 1943, to extend the scope, and change the name of their division, making it conform with that of the similar section in the American Medical Association. The suggestion is worthy of serious thought.

MEDICAL JOURNALS FOR MILITARY COLLEAGUES

An Obligation to Physicians in Camps of the Armed Forces.—On pages 169 and 201 of last month's issue, a plan was outlined through which, with proper coöperation by physicians who are still in civilian practice, it will be possible to send forward every month to hospital camps in California, publications through which colleagues who are stationed at the various fields, will be able to keep somewhat in touch with current medical literature. As then stated, there is a larger number of such California camps than is generally appreciated, and at some of these practically no library facilities are yet in operation.

Most of our colleagues who have entered the services did so with such abruptness that arrangements for transmittal of medical publications were overlooked or could not be made. Moreover, the journals to which they had subscribed, under the second class postal regulations, cannot be forwarded from their homes to their stations except with extra postage.

The California Medical Association, through its Postgraduate Committee, is making an effort to help solve this need, and in the work is being generously aided by the staffs of the three medical libraries in California: the U. C., Stanford, and Los Angeles.

* * *

How Physicians in Civilian Practice Can Aid.—Physicians in civilian practice are requested to scan, as promptly as convenient, the journals to which they subscribe, and then deposit, mail or ship them to one of the three libraries, or to the C. M. A. Postgraduate Committee, 450 Sutter, San Francisco, which ever place may be found the most convenient. The needs of our military fellows may be appreciated if we will but try to visualize the situations which arise, when colleagues are suddenly cut off from the routine of past professional practice, to be transposed to places where the duties of the day are altogether different, and where opportunities for professional or other reading may be greatly limited.

* * *

Places to Which Your Journals May be Sent.—For convenience of readers, some informative paragraphs from a recent letter, follow:

"The Postgraduate Committee of the California Medical Association has taken over this work and will be glad

* In this issue, see page 259.

to render all possible aid in collecting and forwarding medical publications that may be left with county medical society officers, or with hospital staff executives.

"If it is not convenient for you to place with, or forward to the University of California, Stanford or Los Angeles County Medical Libraries, journals that have been collected, the same may be forwarded, via 'Railway Express Agency,' collect, addressed to the C.M.A. Postgraduate Committee, Room 2004, 450 Sutter, San Francisco. The Committee will then be happy to carry on from that point, as regards distribution to suitable military hospital stations.

"Perusal of the editorial comment on this subject in the September issue of CALIFORNIA AND WESTERN MEDICINE will acquaint you with details of the plan. This letter is written to bring home to you the importance and urgency of early cooperation.

"The hope is also expressed that an attempt will be made by your respective officers, or a special volunteer or other committee appointed for the task, to carry on this work from month to month, so that the supply of medical literature may regularly go forward.

"Thanking you for your cooperation,

"THE CALIFORNIA MEDICAL ASSOCIATION
COMMITTEE OF POSTGRADUATE ACTIVITIES."

"The addresses of the three libraries follow:

U. C. Medical Library, the Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California (Stanford).

Los Angeles County Medical Library, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via 'Railway Express Agency,' collect, to: C.M.A. Postgraduate Committee, Room 2004, 450 Sutter Street, San Francisco, California."

No apology is made for emphasizing again this plan of a procedure of service that will be sure of appreciation by physicians who are already in the armed forces. Their needs and their contentment, if we can somewhat aid in supplying such, should be ample compensation for those of us who are still at home.

Lend a hand!

EDITORIAL COMMENT †

ANAEROBIC BACTERIA IN PYORRHEA ALVEOLARIS

An important contribution to the bacteriology of suppurative periodontitis is currently reported by Hemmens and Harrison¹ of the Department of Bacteriology, University of Chicago.

During the opening decade of the present century dentists almost invariably assumed that "alveolar pyorrhea" is a single clinical entity with one specific microbic cause. Bacteriologists of that period, however, were unable to confirm this belief. Goadby,² for example, who studied smears and aerobic cultures from 100 cases, was unable to associate the disease with any one bacterial type. On the basis of opsonic tests he concluded that periodontitis is a non-specific infection with

normal mouth bacteria, due to an insufficient production of specific antibodies. Bertrand and Valodier³ postulated a nutritional deficiency as the underlying cause of this inadequate antibody production. On the basis of these theories a large number of dentists employed autogenous vaccines or vaccines made from normal mouth flora, but with disappointing results.

On account of this failure, the theory of immunological deficiency was quite generally discredited, and renewed attempts were made to find the presumptive specific etiological factor. Among the organisms emphasized by most investigators have been staphylococci, either acting alone or in association with streptococci, or with fusospirochetes. Amebas acting in symbiosis with normal mouth bacteria led to the hope that emetin might be a specific cure. It was later evident,⁴ however, that these protozoa lack invasive power, are never found in living periodontal tissues, and probably act merely as non-pathogenic scavengers.

More recent investigators have called attention to the incompleteness of the experimental evidence thus far accumulated. Almost all of the earlier investigators limited their tests to the simpler aerobic techniques, leaving a large group of anaerobic microorganisms not yet adequately investigated. Hemmens and Harrison attempted to supply these missing data. They made parallel study of the anaerobic flora of healthy gingival crevices and suppurating periodontal pockets, with tests of pathogenicity by animal inoculations.

Eight different groups of obligate or facultative anaerobes were isolated from both exudates and normal gingival surfaces. The two floras differed only quantitatively from each other. Thus spirochetes were readily demonstrated in 100 per cent of all exudates, but in only 61 per cent of the normal cases. *M. gazogenes* was more often present on normal surfaces than in pus pockets. *Fusiformis nucleatus* was found in equal number in both cases. The conclusion was drawn that the anaerobic flora of the pus pocket is the same as that of the normal gingivae, there being quantitative difference in the relative percentages in the mixed flora. Inoculation of mice with pure cultures of these microorganisms or pure culture inoculation beneath the gingival mucosa of normal monkeys gave no evidence of individual pathogenicity. Even in monkeys suffering from "vitamin M deficiency,"⁵ only a transient gingival inflammation was produced, which healed in about 4 days. No differences were demonstrable between the normal and suppurative floras by specific agglutination tests.

Since no one anaerobic species seemed to be the specific etiological factor it seemed probable that a symbiotic relationship existed that might be the essential pathogenic factor. Such associations are well known in other diseases, such as in Vincent's angina⁶ and lung abscess.⁷ In order to test this possibility periodontal pus diluted with broth or ascitic fluid was injected subcutaneously, intratesticularly, intraperitoneally, or intranasally into normal rabbits or mice. Small well localized abscesses developed in a few of these animals,

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

which however usually healed completely within one week to 10 days. Attempts to infect a second animal from these temporary abscesses, however, were unsuccessful.

Since normal animals were thus relatively resistant to the mixed flora of periodontal exudate, scorbutic guinea pigs were then tested. These vitamin C deficient animals died within 10 days to two weeks of a progressive infection, usually including invasion of the blood stream. By inoculating normal guinea pigs with exudates from those scorbutic animals an infection was produced that was capable of indefinite serial passage in normal guinea pigs or rabbits. The mixed periodontal flora in these passage animals was characterized by a progressive increase in virulence accompanied by a decreased complexity. Of the 16 different organisms present in the initial alveolar pus, only 11 organisms were recovered from the first generation in scorbutic animals, and but 8 bacterial species after 7 subsequent serial passages in normal animals. After this passage a stable symbiotic mixture was established.

Subcutaneous inoculation of guinea pigs with this stable mixture produced an acute infection characterized by extreme prostration and death within 48 hours. The phlegmon spread rapidly over the ventral surface of the animal, and usually involved most of the subcutaneous tissues of the chest and abdomen at the time of death. With gentle traction the muscles of the chest and abdomen could be pulled away, leaving ragged shreds of necrotic tissue. The accompanying visceral lesions usually consisted of swelling and hemorrhage into the adrenals and a slight pneumonic consolidation. The adrenal lesion suggests a toxin production by the symbiotic anaerobic flora, though the nature of this presumptive toxin has not yet been determined.

In order to determine whether or not the normal gingival flora is capable of producing the same pathologic picture, similar passage was attempted with material from the mouths of 2 persons having normal gingivae. The infection in the initial scorbutic guinea pig was slower to develop than in previous tests with periodontal pus. After 7 subsequent serial transfers in normal animals, however, the virulence of the normal flora had been increased so that it now produced lesions similar to those produced by the stable mixed flora for periodontitis. The normal gingival flora, therefore, has a potential virulence equal to that of the mixed flora of periodontitis pus.

This finding renders it highly improbable that bacterial invasion is the primary cause of suppurative periodontitis. It seems probable that local and systemic conditions, such as unfavorable mechanical relationships supplemented by vitamin deficiency, cause a primary breakdown of normal periodontal tissue with "pocket" formation. The normal gingival flora gaining admission to this "pocket" presumably acquires a sufficient virulence (or synergic balance) to be able to invade the adjacent healthy tissues and thus produce the

terminal suppurative phase of the disease. Anaerobic bacteria, therefore, may be pictured as little more than secondary invaders, of relatively little importance from the prophylactic point of view. This is in line with the view already held by many periodontologists on the basis of clinical observation.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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RABIES EPIDEMIOLOGY AND CONTROL IN LOS ANGELES COUNTY*

H. O. SWARTOUT, M.D.

Los Angeles

AND

C. O. HARVEY, M.D.

Los Angeles

LOS ANGELES County has had an animal rabies problem for a long time, there having been only one year in the last fifteen when the incidence fell below 300 cases. Fortunately, the number of human cases have been few, though fairly recently five such cases occurred within a period of two years.

In May of 1941, a case of "furious" rabies occurred in which the problems of tracing contacts and controlling secondary cases presented so many characteristic features that the story is unusually interesting and instructive. The dog concerned was shot by a peace officer on May 16. The person on whose premises the animal was shot, fearing legal complications because it was wearing a collar and license tag, removed the collar and tag and buried the carcass shortly before word reached the Health Department of what had happened.

Prompt and judicious inquiry on the part of the local quarantine officer resulted in getting possession of the dog's head, collar and license tag, which made possible a confirmation of the diagnosis and enabled the dog's owner to be traced. From him it was learned that the dog had been given to him on May 10, and had run away from home on May 14 after fighting with several dogs in the neighborhood.

Knowing the place from which the dog started to run and the place where it was shot, a great

* From the Bureau of Preventable Diseases of the Los Angeles County Health Department and the Office of Communicable Disease Inspection.

WARTIME INDUSTRIAL HEALTH

Presenting a symposium of addresses—in full or in abstract—given at Institutes on Wartime Industrial Health, held in the cities of San Francisco, Crockett, Oakland, San Diego, Inglewood, Glendale, and Huntington Park, on August 18-28, 1942. Institutes were sponsored by the California State Board of Public Health, California Medical Association, and Western Association of Industrial Physicians and Surgeons.

ORIGINAL ARTICLES

OBJECTIVES OF THE INSTITUTES ON WARTIME INDUSTRIAL HEALTH*

ROBERT T. LEGGE, M. D.
Berkeley

THE Western Association of Industrial Physicians and Surgeons, at their annual meeting in May, 1942, appointed an educational committee to plan a series of institutes on industrial health similar to those held in Iowa in 1941. The California State Department of Public Health made available the necessary funds and provided personnel to assist in the organization of the Institutes. The California Medical Association, through its Committees on Postgraduate Activities and on Industrial Practice, and the county medical societies cooperated as part of their educational program.

These three important agencies, recognized as leaders in promoting public health within our State, cooperated to present this educational program in postgraduate instruction for plant and private physicians, as well as for others interested in the field of industrial medicine and hygiene.

The transformation of California from an agricultural into an industrial State as a result of the war has created boom-town industrial areas in which the facilities for housing, sanitation, and medical care are taxed to the utmost. The Army and Navy have disassociated from private practice practically all our able-bodied physicians under 40 years of age, so that it has become necessary for general practitioners not in service to take refresher courses in industrial health to keep our assembly lines at their fullest productivity.

The institutes were brought to seven centers of war industries in our State so as to afford plant, part-time, and private physicians an opportunity to attend, as well as public health officers, safety engineers, nurses, and plant managers. The program was planned to review the general principles of industrial medicine and hygiene and to give attention to the practical industrial health problems which the physician encounters in the course of his day's work.

* Abstract of Chairman's address at the Institutes on Wartime Industrial Health in San Francisco, Crockett, Oakland, San Diego, Inglewood, Glendale, and Huntington Park, August 18-28, 1942.

Chairman is Professor of Hygiene, Emeritus, University of California, Berkeley, California.

In promoting industrial, personal, environmental, and community health, the emphasis is placed upon prevention. The main objective is to lessen the incidence and severity of accidents, occupational diseases, and the communicable diseases by making the fullest possible use of the advances made in scientific medicine and in safety engineering. Both the employer and the employee benefit by better health, greater efficiency, and increased production.

This then is the keynote of the discussions presented by my colleagues—prevention by practical and up-to-date methods of the occupational diseases, the communicable diseases, and the general illnesses which affect our working population.

6 Roble Road.

INDUSTRIAL HYGIENE IN WAR PRODUCTION*

J. J. BLOOMFIELD
Washington, D. C.

THE State of California leads the Nation in the volume of war production. That single fact means that California has the same production problems as the rest of the country, only bigger and faster. Three years ago agriculture was the chief industry in California. That is no longer true. When agriculture had to drop out of number one on the California occupational parade, the rapid industrial upswing raised new problems, as is evidenced by the fact that California's accident frequency rate is at least double the percentage increase in employment.

The man—or woman—who leaves the plow to pick up the riveting gun, the monkey wrench, or the welding torch, steps into a new world. Twenty-five years ago the science of industrial hygiene might have been a pioneer in this new world, but I am happy to say that many of the charts have since been mapped, and many of the trails have since been blazed over a generation of medical, engineering, and chemical research—so that today every man whose job it is to conserve American manpower can face that job with the assurance that comes from having a reservoir of industrial hygiene "know-how" which he can tap at any time. But there is a gap between our "know-how" and the application of that slowly-

* Address presented at the Institutes on Wartime Industrial Health in San Francisco, Crockett, Oakland, San Diego, Inglewood, Glendale, Huntington Park, California, August 18-28, 1942.

From the Division of Industrial Hygiene, National Institute of Health, U. S. Public Health Service.

Author is Sanitary Engineer; Chief, States' Relations Section, Division of Industrial Hygiene, National Institute of Health, U. S. Public Health Service.

won knowledge. In its simplest terms, our job is to bridge that gap.

War, however, has brought about certain conditions which greatly complicate the problems of industrial health. Although specific defects are as varied as the enormously diversified war industries themselves, the national problem presents four broad conditions which exist to a greater or less extent in all of the 48 States. The first problem is the one which perhaps has the highest degree of visibility. I mean the control of hazards which are found in the working environment. The second group of problems are those which arise from the community environment. The third problem is the physical composition of the war labor force as compared to the peacetime labor supply, and our fourth is the shortage of trained personnel in the various professions concerned with health conservation in industry.

THE COMMUNITY ENVIRONMENT AND THE WORKER

I do not propose to discuss the first problem, hazards which are found in the working environment. However, before I leave this subject entirely, I should like to emphasize one or two important factors relating to the occupational disease problem.

To begin with, although there may be no new outstanding occupational disease problems as a result of the war, we are faced with an aggravation of the old ones on a tremendously larger scale. Because of priorities, many highly-toxic materials which had practically disappeared from industry are now back in the limelight. More private physicians with practically no experience in the field of occupational diseases are called upon to do this type of work. As a result of these various problems it is necessary, now more than ever, that physicians inform themselves concerning the occupational diseases. It is extremely important that the physicians strive to obtain an accurate occupational history of each patient, so that the factor of occupational exposure may be taken into consideration in the diagnosis and treatment of the disease from which the worker may be suffering. It is also very necessary that the medical profession assume the same attitude concerning the reporting of occupational diseases that it now does toward the reporting of communicable diseases. It is only by such a procedure that the official agency responsible for investigating and controlling an occupational disease will have the necessary information to do so.

The health problems which arise in the community stand in the same relation to health problems within the factory gates as does the nine-tenths of an iceberg which is under water to the one-tenth seen above the surface. Less than one-tenth of time lost from work is due to accidents and illness on the job. More than nine-tenths of the 400 million working days lost last year—a peacetime year of tooling-up—were due to *non-occupational* illness and injury.

The industrial hygienist is well aware that his

efforts to insure a safe and healthful working environment are often nullified by unfavorable conditions in the community. A worker who is absent from his job because of a serious cold is as surely lost from the production line as though he had been disabled by an accident or an occupational disease, such as lead poisoning. Quite plainly, then, individual health—*worker's* health—and community health are so closely interwoven that one cannot be considered without the other.

The rapid expansion of war industries has had an incalculable effect upon the provision of adequate community service in many parts of the country. For example, the war contracts allotted to date have been very unevenly distributed geographically. At one time, 73 per cent of the war contracts were allotted in 20 industrial centers containing 22 per cent of the total population. The State of California is the leader among these areas, and the impact has been felt not only in tremendously increased industrial activity, but also in a severe strain upon community facilities of all sorts—transportation, schools, hospitals, medical and public health services.

As a result of war production, there is in motion a vast transmigration of workers and their families. New war plants are being built in rural areas with little thought to the provision of even rudimentary facilities, such as adequate housing, safe water, and sewage disposal. In industrial centers like those in this city, the demand for war workers has not yet reached the peak, and community health facilities in many areas are already cracking under the strain.

Under the Community Facilities Act, Congress has appropriated some \$300,000,000 for the construction of schools, hospitals, water supply, sewage disposal, and other public works in war areas. This sum was about \$50,000,000 short of the estimated cost of essential construction at the time of the attack on Pearl Harbor. By March 31, 1942, the U. S. Public Health Service had certified 808 health and sanitation construction projects in war areas; 612 of these had been approved by the President. Construction, however, had been started in only 172 instances, and a mere 8 projects were completed. As of June 27, 1942, California had made 396 applications for projects, estimated to cost 99 million dollars. However, only 169 of these projects had been approved by the President at that time, amounting to an estimated cost of 24 million dollars. The projects requested were mainly hospital additions, waterworks, and sanitary facilities.

With the crowding in factories, crowding in homes, crowding in transportation facilities, war industries are under constant threat of outbreaks of contagious disease among employees, which would seriously disrupt production. Every necessary precaution must be taken to avoid such an occurrence. The strengthening of general public health services in the community thus becomes an essential part of the industrial hygiene program. The industrial physician should be able to

rely upon his local health agency to fight this rear-guard action in support of his front line attack against time-loss in our war production drive. To help the States hold the line against preventable disease, the United States Public Health Service, under emergency appropriations by Congress, has recruited and trained 700 professional workers—physicians, engineers, nurses, technicians, and others—and assigned them to duty, under the direct supervision of State health departments, in 176 critical war areas.

Thus, although actual performance still falls far short of immediate needs, a good beginning has been made in the provision of minimum public health facilities in war areas. Further improvement must come, in large part, through a more realistic facing of the problem by the States and communities involved.

Crowding, poor housing, lack of sufficient medical facilities, schools, recreation, and other welfare services all combine seriously to threaten health and to disrupt normal family life. Add to these the mental strain caused by war worries, and we have a situation (under which thousands of war workers are now living) which is certainly not conducive to good morale and all-out production.

The disruption of community facilities is perhaps the first "medico-economic syndrome" to be felt in the industrial physician's practice, and equally one of the last to be recognized. Industrial medicine can no longer confine itself to emergency treatment and the diagnosis of occupational diseases. True, there is a bigger job to be done in the plant itself—that is, a job of prevention. But even this cannot be accomplished without a prompt and responsible recognition of the influence of living conditions upon absenteeism and industrial disability. This is a "total war"; half-way measures, half-way acceptance of responsibility, and a half-way concept of the job will not win. In dealing with the worker, we must adopt a concept of the "total man" if we are to keep him on the job and enable him to contribute to the common cause—his utmost in high morale, vigor and efficiency.

COMPOSITION OF THE WAR LABOR FORCE

The Honorable Paul V. McNutt, Chairman of the War Manpower Commission, reported two weeks ago that 12½ million men and women are now at work in war plants. He predicted that 5 million more workers would be needed within the next six months. By the close of 1943, these figures will undoubtedly have increased to be between 20 and 25 million workers in direct war work and essential contributory industries. More men and women will then be employed in industry than ever before in our history.

As a matter of fact, the increased employment of women is—and will be—one of the most notable changes in our industries. Thirteen million women are at work today—with the number of women in direct war work climbing toward 2

million this year, and up to 7 million—by the end of 1943.

By mental attitude and physical aptitude, women can handle many a so-called "man-size job." In one California plane plant alone, women are now handling 38 different jobs, from milling machine and turret lathe operator to sewing machine operator and parts stamper. In the entire plant there are only 9 jobs to which women definitely are not suited because of physical requirements, and five for which the required training is too long to warrant introducing women.

The employment of women, especially in the heavy industries, presents problems too numerous for discussion in the short time left. But the industrial physician must recognize the problems which exist—the 60 per cent higher morbidity rates from various nonindustrial diseases, for example—and must solve these problems promptly if womanpower is to supply its full share of war manpower.

To win the war, we must use *all* of our manpower. As a Nation we have accepted the fact that until the war is over, there will be no "business as usual" for any of us. Many peacetime standards will have to be revised. We are salvaging rubber, aluminum, copper, scrap iron, tin, so that we can meet shortages in strategic materials. Likewise, we must salvage those workers who are handicapped by both major and minor disabilities. Our physical standards for employment have been rigid and arbitrary, and, in many cases, unnecessarily high. These standards are still being applied in war plants, and valuable workers with physical defects are being turned away.

The War Manpower Commission has already discussed the possibility of calling upon management to review and adjust these standards to immediate needs. The industrial physician has a definite responsibility in influencing and guiding decisions with respect to the employment of handicapped persons. We have said for many years that the preemployment examination *must* be used as a tool to place *all* workers—including the physically handicapped—in jobs best suited to their capacities, jobs in which performance will be at required efficiency without unusual hazard to the worker or his associates. The preemployment examination must be used as a *preplacement* examination.

Detailed knowledge of the jobs in a given plant should be a part of the industrial physician's equipment—not merely knowledge of the number of vacancies, but of the actual operations, the potential exposures, and the required physical capacity for each operation. This kind of knowledge is not to be acquired by reading reports, but by personal study of the problem in the shop. Knowledge of the job, combined with the physician's knowledge of the human organism, will make it possible to salvage many thousands of physically handicapped workers for participation in the war production drive.

We must recognize that many of our new workers—the women, the under-draft age youngsters and the older men—are working longer and harder than they ever have before. The question of fatigue immediately arises. A tired man or woman is a potential danger to himself and his fellow workers. The increased demands for skillful and precise work mean a higher percentage of wasted efforts and spoiled critical materials from the tired worker's bench.

The Office of War Information announced on July 29 that 8 Federal agencies—War and Navy Departments, Maritime Commission, War Manpower Commission, War Production Board, the Department of Commerce, the Department of Labor and the Public Health Service—had jointly subscribed to a policy of urging a 48-hour week limit in war plants. This policy is in line with a statement issued by Surgeon General Thomas Parran seven months ago in which he pointed out that industries operating on a 24-hour basis must take special precautionary measures to minimize the effects of night work and the rotating shift. A copy of that statement is in your hands.

Also associated with fatigue is the disruption of eating and sleeping habits among workers employed on second and third shifts, especially with change of shifts occurring too frequently.

Physical fitness in the workers is the basic requirement for the reduction of lost time due to fatigue. Proper adjustment of hours, improvement of the working environment, job simplification, reduction of noise, and provision of rest periods, with supplementary feeding, will contribute to the control of fatigue.

Improved nutrition is an important factor, not only in combating fatigue, but also in promoting a higher level of health. Up to now industry has paid little attention to the nutrition of workers. Some of our newest plants are making no provision for cafeterias in the establishment, or even convenient to the plant. Great Britain has had to make the provision of eating places compulsory in all factories employing 250 or more persons. Similar action may be expected in this country if the present educational program fails to produce results.

SHORTAGE OF TRAINED PERSONNEL

Our final wartime problem—the shortage of professional personnel—makes teamwork in industrial medicine even more imperative. According to the American Medical Association, more than 20 000 additional physicians will be needed by the military services before the end of the year. Eight states, of which California is one, will have to supply nearly 16 000 of this number. Furthermore, the armed forces will need the entire First Reserve of the American Red Cross, 2,000 of whom will come from California.

Reports to the United States Public Health Service indicate that in hundreds of industrial communities the lack of doctors, dentists, nurses,

is acute, and in many the situation is indeed grave. Early in February of this year, Surgeon General Thomas Parran reported that there were 1,000 vacancies for qualified physicians in State and local health departments, and 2,700 vacancies for public health nurses. In civilian hospitals, there are 10,000 vacancies for registered nurses. Individual cases have come to our attention in which the staff of industrial medical services in war plants is being depleted by the induction of personnel into the Army or Navy.

As you know, the Procurement and Assignment Division of the War Manpower Commission is pressing forward as rapidly as possible with its program for the effective utilization of the medical and dental personnel of the Nation. Even with adequate adjustment of the present situation, we must all face the fact that there will be a considerable shortage of professional personnel. The needs of our increasing Army and Navy must be met.

Nevertheless, there is a growing concern on the part of numerous war agencies and the Council on Industrial Health of the American Medical Association, lest adequate measures be not taken for the health protection of our vast industrial army. This would seem to place industrial medicine on the horns of a dilemma.

In order to help meet this problem, the Public Health Service has increased the staff of the Division of Industrial Hygiene of the National Institute of Health to 200, and has in addition employed and given special training to nearly 50 industrial physicians, engineers, and chemists who have been assigned to duty in State industrial hygiene services. Five of these are assigned to California. There is available, then, in the Federal service and in the 45 State and local industrial hygiene units, an organization of more than 500 trained professional workers capable of giving active assistance to the industrial physician. Through inspections of plants, medical and engineering consultation, and laboratory services, an effective program for the health protection of workers in individual plants is available. It only remains for these services to be more widely used by industry than they are today.

The problem of providing medical service in small plants is of increasing importance, since the allocation of Government contracts has brought many of them into the war production drive. The Council on Industrial Health of the American Medical Association, in a recent joint session with the Subcommittee on Industrial Health and Medicine of the Office of Defense, Health and Welfare Services, recommended that a program of instructing management in the advantages of medical supervision over workers be undertaken by the Government. At the subsequent meeting of the National Conference of Governmental Industrial Hygienists, the Conference recommended that a similar program be undertaken by the Public Health Service.

The answer to it all would appear to be in

organizing adequate industrial hygiene measures and maintaining the utmost vigilance. Medical, engineering, and safety personnel must constantly be aware of these problems. More than this, they must bring new problems to the attention of management and supervisory personnel, lest the pressure for high-speed production cause them to neglect the health and safety of workers, and to discount the importance of conserving our vital manpower.

Our air force has the answer for industrial medicine. We do not hear about a bomber, or a pilot, or a navigator, or a bombardier any longer. We hear about a "crew," a team—operating with incredible skill and bravery, each dependent upon the skill and loyalty of the other. The industrial physician can meet his enemy—carry out his mission—if he learns to operate as a team, drawing upon all the resources available to him. Teamwork begins in the plant, between management, labor, the medical service, the engineering service, and the employment department. Other resources should be utilized as well: the private practitioners of medicine in the community; Federal and State industrial hygiene services; local public health authorities—all should be focused upon the supreme task now before us, namely, the conservation of manpower in our war industries.

We should also utilize the worker himself in doing everything possible to maintain his physical and mental fitness so as to lessen the burden on the industrial hygienist. The labor-management committees organized in war plants by the War Production Board should be a valuable channel for the dissemination of health information and for voluntary acceptance of industrial hygiene. On July 13, 1942, 65 California plants had such committees.

We have all seen the slogan, "We have no time to lose." To that I should like to add, *we only have time to win! Time* is indeed of the essence. Time to outstrip the start which our enemies have had on us for many years. Indeed, our shortage of certain vital materials and of professional personnel are insignificant compared to our shortage of time. There is no substitute for the hours and days lost in war production because of disabling sickness. There is no substitute for the lives lost in accidents. Industrial medicine has the clear responsibility and the prodigious task of conserving every ounce of energy and efficiency in our war workers. The new and renewed problems are troublesome; but, in most instances, we have the "know-how" to meet them. War hits hard and it hits fast—in every phase of our national life. The industrial hygienist must hit first, and hit harder, if we are to give our working army the health and strength to keep 'em rolling.

U. S. Public Health Service.

INDUSTRY'S MANPOWER: ITS CONSERVATION*

CAREY P. MCCORD, M. D.

Detroit, Mich.

THE true value of the trained industrial worker participating as an industrial soldier in the present emergency can be computed in various terms. However, all values are so rapidly shifting that there is no valid method of placing a monetary value on such a workman.

Of the total population of this country, there are only about 55,000,000 persons, men and women, young and old, available for all work purposes including military service. Considering the requirements for the military services, for production in war industries, for agricultural labor, and other nonmilitary but still essential activities, there is, in prospect, a deficit of nearly 6,000,000 workers. Women and old men will be called upon to make up this deficit.

It is here that the medical profession steps in. These men and women must be conserved to build more and more war materials, next week, next month, and next year. This conservation job belongs to everyone, but foremostly to the doctor, the industrial hygienist, the nurse, the public health official, the safety engineer.

Conservation of the Nation's manpower touches every physician just as war itself touches every person. In at least two senses all practicing physicians are industrial physicians. First, it should be recognized that over the country, as a whole, 80 per cent of all strictly industrial medical work is carried out by physicians not full-time or part-time salaried associates of industry. Although war will perhaps increase the percentage of medical work carried out on work premises to a figure somewhat greater than the remaining 20 per cent, this augmentation will not greatly lessen the private practitioner's dominance in this field. Not only the general practitioner, but every specialist, whether he be fully aware of it, frequently is seeing cases of total or partial employment origin.

Secondly, all physicians have been brought closer to industrial health through the realization that work injuries and occupational diseases make up only a minor portion of the health conservation problems of industry. A man or woman worker unable to perform work duties because of illness unrelated to work as the cause is just as much of a hampering influence to production as though the disease or injury had been produced on the plant's premises.

Out of an almost unlimited list of opportunities for the medical profession to wield an influence helpful to the conservation of the Nation's man-

* Abstract of address presented at the Institutes on Wartime Industrial Health in San Francisco, Crockett, Oakland, San Diego, Inglewood, Glendale, and Huntington Park, August 18-28, 1942.

Author is Medical Advisor, Chrysler Corporation; Medical Director, Industrial Health Conservancy Laboratories; Director, American Association of Industrial Physicians and Surgeons.

In life, as in a football game, the principle to follow is: Hit the line hard!

—Theodore Roosevelt, *The Strenuous Life: The American Boy*.

power, several topics that may equally well apply to physicians in and out of the walls of industry are selected for specific comment.

HOURS OF LABOR

There are fairly definite physiological limits to the amount of work that may be performed, and that work physiology should be the prime consideration determining upper limits of work periods, short of any imminence of early and nearby attack. Every worker should have at least one day in seven, but not necessarily Sunday, for rest, recuperation, and recreation. Failure to observe this measure cannot be long continued without definite and measurable harmful results. Although variations exist from trade to trade, it is generally true that work under proper hygienic conditions does not reach its physiologic limits until about the 54-hour week level. Further, British experience has clearly demonstrated the utter undesirability of excessively long hours, that production is best served by adjusting work periods to physiologic capacities.

SWING SHIFTS

In order that essential industries may continue to operate 7 days a week and 24 hours a day, the introduction of swing shifts is necessary and commendable, but the method of swing shifts becomes a matter of physiologic concern. From a physiologic work point of view, changes of workers are best made from shift to shift only at some long interval such as 2 months, and better, 3 months. The physiologic adjustment is more easily made when there is some continuation of any one set of requirements.

INDUSTRIAL NEUROSES

In recent times, there has been much connected with industrial pursuits conducive to the appearance of neuroses. Never has industrial medicine adequately accepted responsibility for industrial psychiatry. Much less so, has there been any proper understanding on the part of the general medical profession. Under these circumstances, if the medical profession would serve industry and the Nation, more and more attention should be paid to industrial psychiatry. In every industrial community, there should be competent psychiatrists for the education of industrial physicians, for direct consultation, for the devisation of suitable programs, for the abetting of recreational activities. Every medical society should have an active committee on industrial psychiatry.

PUBLIC AGENCIES

The mass of physicians may not be expected to be in a position to know all of the ins and outs of industrial exposures, the causes of occupational diseases, the means for measuring and controlling dusts, gases, vapors, noise, and other exposures. But all physicians should know that there are available to them and to industry, state and city agencies, such as bureaus of industrial hygiene, and semi-public agencies in the form of

insurance company services, all of which are eager to serve industry and physicians. Thus every physician has available to him a staff of trained workers that should be utilized.

ABSENTEEISM

It is difficult for most persons to realize the tremendous losses that arise from unnecessary absenteeism from work. The taking of a day off here and there as a deliberate measure and in the absence of sickness is a praiseworthy thing and not to be condemned. But for industrial workers this may be carried too far. We have conditioned ourselves to believe that a double absentee rate on the part of women workers is somehow or other inescapable. I know of scant valid reason for any such double absentee rate except the fact that household duties, particularly where there are children, weigh heavily upon women workers. Never can all of absenteeism be eliminated, but if absenteeism might be reduced by one-half, the war might be won in a year's less time—but no one knows the real facts. All physicians share in the responsibility of keeping workers at work, out of hospital beds, out of unnecessary sitting by the fireside, away from the necessity of caring for sick children, and away from 4-hour waits in the waiting room of all too busy physicians.

INCREASED KNOWLEDGE OF INDUSTRIAL ACTIVITIES

Physicians know too little about industry. Often their attitude comes from that of the worker patient, who himself may harbor the most garbled notions about his work conditions. The more physicians know about industry in all of its ramifications, the better qualified they are to serve workers, industry, and the country.

At some future time, one year or five, this war will be won. For many physicians there will be no medals, no uniforms, no parades. In fact, there may be scant tangible evidence that these physicians participated at all in the conservation of the Nation's manpower at the time of war. Yet every physician has opportunity to serve the industrial armies. Even though there never be any praise, he will be able to face himself as he shaves before his mirror and to have his own private and laudable S.D.W.P.—"A Sense of Duty Well Performed."

SAN FRANCISCO MANAGEMENT LOOKS AT INDUSTRIAL HEALTH*

FRANK P. FOISIE
San Francisco

MANAGEMENT has looked upon industrial health in the only way the layman can look to the professional—up—a sort of worm's eye

* Abstract of address presented at the Institutes on Wartime Industrial Health in San Francisco and Oakland, on August 18 and 21, 1942, respectively.

Author is President, Waterfront Employers Association of the Pacific Coast, San Francisco, California.

view! That is, where management has looked at all. Much of the time, industry has taken for granted that the worker is in good health, and that it is up to him to keep that way. There are many notable exceptions, but industry has not generally included in its obligations or opportunities a program of organized industrial health.

Management in war industries, with its present responsibility for the production of materials in astronomical quantities, now finds it necessary, in order to fulfill that responsibility, to improve and maintain the health of its available manpower. The surplus of labor, which made it possible for industry to make a free selection of its manpower, no longer exists.

Management looks to the physician for guidance and direction in the vital and growing field of industrial health. With the necessity to utilize all available sources of manpower, the industrial physician can institute adequate standards for health conservation of this manpower, as for example, in the employment of women. Secondly, the industrial physician is free of the severely limiting economy of competition because, today, any measure that advances the war effort is supported without stint. Thirdly, management looks to the physician for guidance in the broader problems of industrial health, such as proper placement and not rejection of workers, education in nutrition and personal hygiene; protection on the job from hazardous working conditions; and prevention and control of the general illnesses.

Another resource which the industrial physician now has is the joint interest and coöperative support of organized labor and management. Further, the evergrowing interdependence of persons and functions in modern industry make for improved relationships and for greater freedom to carry out one's functions, because one is freed of the limitation of working alone.

Another factor of importance to the physician is that business is organizing into associations on an industry-wide basis for the self-regulation of industry in its relations with labor and with government. Thereby, the industrial physician's field of work is enlarged, and his effectiveness increased because there is a whole industry to serve rather than a single plant. Not least significant is that in each such organized industry, "the best lead, the rest follow."

Our fighting service men are the best cared for of those of all the nations. It is our task in industry that the same may come to be said of our civilian service men. The challenge alike to the medical fraternity, to organized labor, and to organized management is to secure an abundant and vital health in industry, the like of which we have never known, so that we may produce for war to the utmost.

It is said of Gladstone that he gauged a community by the care it gave its cemeteries. Let an industry be gauged by the care it gives its health.

Federal Reserve Bank Building.

LOS ANGELES MANAGEMENT LOOKS AT INDUSTRIAL HEALTH*

V. R. NABORS
Los Angeles

WITH the advent of the present war, management finds it necessary to focus its attention more and more on the health of the worker.

Although much has been done in accident prevention, progress in medical and health programs is slow of development because management is reluctant to accept suggestions, in the absence of statistical proof that a plan is workable, especially if an additional burden of overhead is required.

Estimates place the lost time arising from disabling illness as high as 2 per cent, and for every person incapacitated because of illness, at least two others are handicapped because of prevalent or chronic diseases to the extent of 10 per cent to 50 per cent of their efficiency. The few studies that have been published show that lost time due to illness and nonindustrial accidents is approximately twelve times as great as lost time due to industrial accidents. Absenteeism due to industrial or occupational diseases probably does not exceed 3 per cent of the total absenteeism.

However, management dislikes estimates and theories, and prefers specific reports such as that of the National Tuberculosis Association or of the R. H. Macy Company, New York City, as published by the National Industrial Conference Board. In 1926, Macy's spent \$4.40 per employee per year for medical care, but as the program for preventive medicine expanded, the per capita medical cost gradually rose to \$8.74 in 1938. Although the average age of employees increased somewhat during this period, the death rate followed a downward trend, and at the low point of 1935 was 50 per cent less than in 1926. Not only did the death rate decrease, but resignations due to poor health dropped from 9.78 per cent in 1926 to only 1.82 per cent in 1938.

For an organization of more than 10,000 persons, absenteeism is not only costly but difficult to control. Nevertheless, Macy's total absence rate for all causes declined from 4.56 per cent in 1928 to 2.44 per cent in 1937, or a reduction in the rate of over 46 per cent. In addition, the sick and death benefits paid per \$1.00 in dues collected by the association declined from \$1.24 in 1926 to \$0.95 in 1938, and dividends (skipped dues) were declared in 1932, 1934, and 1935.

The medical director of Macy's believes that the reductions in the mortality and disability rates are directly attributable to the company's health program. Through improved safety and health measures, it has also been possible, during the past 5 years, for the company to effect an annual saving of nearly \$40,000 in the cost of workmen's compensation.

* Address presented at the Institutes on Wartime Industrial Health in Inglewood, Glendale, and Huntington Park, August 26-28, 1942.

Author is Personnel Director, Ducommun Metals and Supply Company, Los Angeles, California.

PHYSICAL EXAMINATIONS

Most large companies use a physical examination as a prerequisite of employment for the purpose of (1) eliminating those persons who are unfitted for the job and of those with communicable diseases, (2) the detection of and prescription for remediable defects, (3) the proper placement of those unfitted for one type of work, but entirely fitted for another, and (4) the maintenance of the health of those who are healthy when employed. Follow-up examinations at set intervals also have proven very helpful.

The effectiveness of a health program in industry depends upon the coöperation and understanding of all employees. Coöperation with the community and local health agencies is likewise an important factor, for the relation between industrial health and local conditions is obvious.

ELEMENTS IN AN ADEQUATE SERVICE

The work of educating employees as to how to protect and preserve their health falls short of its objectives if a company does not provide adequate health service facilities for the workers. The following working principles may be considered essential to an adequate service:

1. A definitely organized plan for health service.
2. A definitely designated staff of qualified physicians, surgeons, and attendants, with one physician in charge of the service.
3. Adequate emergency, dispensary, and hospital facilities.
4. Preemployment and periodic physical examinations, to be made only by qualified medical examiners.
5. Efficient care of all industrial injuries and occupational diseases.
6. Reasonable first-aid treatment and advice for employees suffering from nonindustrial injuries and illnesses while on duty. For further professional care such employees should be referred to their own private or family physician.
7. Education of the employee in accident prevention and personal hygiene.
8. Elimination or control of all health hazards.
9. Adequate records, including physical examination records, from which statistical summaries and analyses of injuries and illnesses should be made periodically.
10. Supervision of plant sanitation and all health measures for employees by the physician in charge.

These principles prevail to some extent or degree in most of the larger companies. In smaller companies an industrial nurse may take the place of a staff physician. In either case, this person should have training beyond the usual requirements in the general principles of personnel administration, unemployment and workmen's compensation, and a general understanding of the processes as they affect the health of the employees. If the medical services are under the supervision of a nurse, obviously her activities would be under the usual restrictions. Therefore,

the advice and service of a local industrial physician should be required periodically.

DUTIES OF INDUSTRIAL NURSES

The duties of the nurse would include:

1. First aid for injuries or illnesses occurring to employees while on duty. This care is given under standing orders from the physician.
2. Subsequent dressings or care for injuries or illnesses.
3. Equipment and supervision of first-aid boxes placed at desirable locations in the plant.
4. Responsibility for the general set-up of the plant dispensary.
5. Assistance to the physician with physical examinations.
6. Assistance to employees in securing correction of physical defects and social problems.
7. Responsibility for keeping individual records for each patient, and preparation of a regular report for management and the physician.
8. Assistance to safety program through active membership on safety committee.
9. Contribution to plant program of industrial hygiene and sanitation.
10. Contribution to good industrial relations through service as liaison between management and employees.

A nurse to administer treatment in case of accident, and to give counsel and instruction on health problems, not only to employees but to their families as well, has been widely used in the eastern States, but the practice is just gaining momentum here. Some of the insurance companies handling group policies have made this service available to their clients. A company may, however, make independent arrangements for a visiting nurse's service by direct employment, or by contract with an association employing several nurses strategically located within the community. Although it is difficult to establish a proper attitude on the part of the employees in regard to the visiting nurse, she can render, nevertheless, most valuable assistance, and be of service where there exists illness and distress. If, however, she finds no sickness and discovers that an employee is out for other reasons and so reports, she is immediately looked upon as a truant officer trying to meddle into the employee's private affairs. Her position is extremely difficult, and she must of necessity be a person with an unusual amount of tact and the ability to invite confidence if she is to render service to workers in the promotion of health within the organization and outside as well.

OTHER REQUIREMENTS

The need, cost, and value of a health-service program will determine its extent. Now, more than ever, it should make adequate provision for problems arising out of the necessity for employing men and women in jobs to which they may be neither accustomed nor entirely fitted. Good health is among the incentives to production and good industrial relations. From an economic aspect, in the light of Macy's experience, it is

possible to reduce amounts paid in sickness and death benefits, amounts paid in workmen's compensation, and the cost of employees' days lost. It may be assumed, although no reliable estimates are available, that the cost to the employer, when experienced employees are incapacitated by sickness, is at least one and one-half times the daily wage. Undoubtedly some of the factors covered in the study of industrial accident costs also apply to sickness, as for example, (1) cost of lost time of sick employee; (2) cost of time of other employees required to do the work of the absentee; (3) cost of time lost by foremen, supervisors, or other executives to select, train, or break in new employees; (4) cost of idle machines; (5) cost due to interference with production; (6) cost under welfare and benefit systems; (7) cost of continuing the wages of the sick employee in full after his return, although his services may be only worth about half their normal value on account of his condition. Such are the hidden costs comparable to those summarized by authorities on industrial accidents.

Let us not forget also the humanitarian aspect. War will reap its harvest while manpower at home will strive to shorten its duration.

219 South Central Avenue.

SAN DIEGO MANAGEMENT LOOKS AT INDUSTRIAL HEALTH*

W. FRANK PERSONS
San Diego

THE objective of management in any industrial enterprise is efficient production. In achieving this end, management must take into consideration all factors and conditions, and must maintain them in actual balance.

Within industry, three of the principal factors conditioning efficient production are: (1) plant and facilities, (2) equipment and machinery, and (3) manpower.

Some of the factors determining the efficiency of manpower in the operation of an industrial plant are: careful selection of working personnel; adequate foremanship; sound organization of working force; maintenance of health and morale of personnel; and satisfactory labor relations.

No one of these factors is solely responsible for the successful utilization of manpower in industry. Even the thesis that health is the primary and most essential factor is too simple to be true. This may be said without disparaging the great importance of industrial health. In seeking the most effective employment of manpower in industry, it must be realized that all of the factors act and react upon each other, that each supports and supplements all of the others.

Absenteeism is one of the important factors limiting efficient production. Statistics on the number of man hours lost in industry through absenteeism are appalling. Thus, it has been reported that in a plant employing more than 40,000 workers, there are as many as 2,000 man days a week lost through absenteeism. A very substantial amount of absenteeism could be prevented by more adequate industrial health programs. Provision of proper opportunity for shopping outside of working hours would lessen absenteeism among women charged also with domestic responsibilities.

Enlightened management does regard industrial health as one of the major essentials in the productive enterprise. Accordingly good management is alert not only to the installation and maintenance of adequate plant facilities and machinery, but is equally alert to the adequacy of its program for industrial health, both at the time of induction and throughout the period of employment of its workers.

Physical examination of employees at the time of selection is the general practice of large employers. According to the results of physical examinations employees may be placed in positions for which they are suited. The reluctance on the part of prospective employees to undergo physical examination which has existed in the past is being overcome rapidly. Most applicants for employment now realize that physical examinations are for the protection of the individual and of the group.

Periodic physical examination of employees is not as generally practiced as is physical examination at the time of induction. As techniques for more efficient production are developed, however, it is possible that periodic health examinations will be as fully practiced.

Preventive measures are of more importance than corrective measures. Here again care should be used in interpreting statistics. Thus, a large number of visits to first-aid stations may mean, not a high frequency of accidents due to lack of safety measures, but that employees have been encouraged by management to visit the first-aid station upon receiving very slight injuries, or upon the occurrence of slight ailments. Lack of visits to first-aid stations may mean that employees are careless with respect to minor injuries, and are inclined to "bluff it through," or even are encouraged in that practice by foremen.

One of the major opportunities of management is health education. In many industrial concerns, management has become quite aware of the importance of continuous education with respect to health, not only on the job but also as to personal hygiene and health in the home. As a result of the heavy demands of war production, management has concerned itself with the problems of housing, transportation, nutrition, and fatigue, because it realizes that all of these have their direct effect on the efficiency of the employee.

Management looks at industrial health as one of the most essential factors in the production

* Abstract of address presented at the Institutes on Wartime Industrial Health in San Diego, August 25, 1942.

Author is Director of Industrial Relations, Consolidated Aircraft Corporation, San Diego, California.

program. The lessons to be learned while war production is essential to our very existence as a Nation will not be forgotten; when we enter the period of constructive peace, we shall find that management will attach still greater importance to the maintenance and development of industrial health programs.

Consolidated Aircraft Corporation.

PHYSICIANS' LEGAL RESPONSIBILITIES IN INDUSTRIAL MEDICINE*

C. H. FRY, ESQ.
San Francisco

THE Roseberry Employer Liability Law of California, which provided for certain compensation, medical and hospital treatment for industrial injuries, was effective September 1, 1911. In the same year, a constitutional amendment authorized the legislature to enact workmen's compensation laws. These laws, which were made effective January 1, 1914, have been amended many times. In 1917 the act was substantially changed, and the term "injury" substituted for the term "accident." Today "injury" is defined as including any injury or disease arising out of the employment, including injuries to artificial members.

At present, the Compensation Act is not to be found in any one code, but most of it can be found in the Labor Code, the Health and Safety Code, or the Insurance Code. Careful study of the codes and of the court decisions which have been made over a period of years on the various phases of the law is necessary to understand the jurisdiction of the Industrial Accident Commission.

The Labor Code requires that every injury, unless the disability resulting from such injury does not last through the day or does not require medical care other than ordinary first-aid treatment, shall be reported to the Commission. In case of death, the employer must submit a report forthwith by telephone or telegraph.

The term "occupational disease" is not used in the law, and is unnecessary because a disease arising out of the occupation is classed as an injury and, therefore, is compensable in the same way that other injuries are compensable. The requirements for reporting occupational diseases are the same as for reporting any other injury. In 1941, there were 450,793 industrial injuries reported to the Commission, and of these, 113,648 were classed as tabulatable injuries, that is, deaths, permanent disabilities, and temporary disabilities

lasting longer than one day. Of the 113,648 injuries, 7,100 were due to "hot, poisonous, and corrosive substances and flames," the classification under which all of the occupational disease cases are included. During 1941, there were 635 industrial deaths, and of these, only 15 were charged to the same heading, "hot, poisonous, and corrosive substances and flames." How many of these could have been classified as occupational diseases, we do not know.

On August 11, 1942, the Commission adopted a resolution providing for the use of standard forms for the reporting of industrial accidents, injuries, or occupational diseases, providing that such injury either disables through the day of injury, or requires medical attention. These forms are for the use of employers, insurance carriers, and physicians, and surgeons.

Many physicians specialize in industrial surgery, but it is only recently that any great number of physicians have given thought to occupational diseases as a group. If the effects on the human body of many of the thousands of chemical compounds that are being put on the market were known to the medical fraternity, provision could be made for protection against the ill effects, if any, of these compounds.

There must be complete coöperation between the chemist, pathologist, pharmacologist, roentgenologist, internist, and the engineer. When the physician states that certain conditions existing in industry are hazardous to health, it is probably within the province of the engineer to provide for the removal or the amelioration of such hazards. Without the coöperation of the entire group, the desired result cannot be achieved.

State Building, Civic Center.

PROBLEMS IN INDUSTRIAL SURGERY*

NELSON J. HOWARD, M.D.
San Francisco

THE surgeon who undertakes to treat an injured workman, covered by industrial accident insurance, immediately involves himself in a series of relationships going far beyond the usual patient-physician relationship of private practice.

The physician becomes at once, judge, recording secretary, bursar, and witness. He may, if so inclined, become a venal biased judge, slovenly recorder, or suborned witness. If he so demeans himself, the true patient-physician relationship is destroyed.

Given the same attitude and interest as shown our private patients, the industrial patient maintains the desired relationship. Under such circumstances, less than one-half of one per cent of in-

* Abstract of address presented at the Institutes on Wartime Industrial Health in San Francisco, Crockett, Oakland, San Diego, Inglewood, Glendale, and Huntington Park, August 18-28, 1942.

Author is Chief, Bureau of Industrial Accident Prevention, California State Industrial Accident Commission, San Francisco, California.

* Presented at the Institutes on Wartime Industrial Health in San Francisco, Crockett, and Oakland, on August 18, 19, and 21, respectively.

From the department of surgery, Stanford University School of Medicine, San Francisco.

dustrial patients are malingerers or develop compensation neuroses.

One must continue to emphasize that the patient-physician relationship involves confidence and coöperation on the part of the injured individual, and sympathy, honesty, knowledge, and skill of application on the part of the physician. Without these factors existing in each particular case, doubt, mutual distrust, and misunderstanding creep in and mar the traditional relationship, and often impede or may even prevent restoration of function.

Without donning judicial ermine, the physician must judge as to supposed cause and effect in relation to disease. He must be able to judge accurately as to the time an injured patient may be able to return to work without impeding recovery, suffering further harm, or endangering others. When, after the best efforts of the surgeon, further return of function is at an end, one must be able to describe in quantitative terms of the normal, the impairment remaining.

Accurate records are a necessity in industrial surgery, and a man who is proud of his surgery and end results should be equally interested in the recording of those same results. Well-kept records prevent acrimonious discussions with insurance companies and with patients, and simplify the bookkeeping and financial records of the physician.

Fortunately, the laws of the State of California do not place the determination of percentage loss in permanent disability upon the physician. The physician's duty ends in this respect when he has described in objective terms the loss of range of motion (as compared to the normal limb or part), the presence or absence of anaesthesia or paralysis, and similar factors which can be measured or tested quantitatively. Here the physician should act as a disinterested expert witness, not as judge or advocate, neither minimizing nor exaggerating defects which he alone, by virtue of his special training, is qualified to detect.

There is one further duty that the physician should assume, and that I urge each one of you to adopt: namely, the part of voluntary safety engineer. The detection and prevention of safety and health hazards in ordinary employment, as well as in large industrial plants, is one of the fascinating parts of industrial medicine. Although insurance companies employ safety engineers, the first awareness of a hazard may come from the physician.

What advantages accrue to the physician who assumes these extra burdens? First, for seriously-injured persons, the physician can work with the best of equipment and assistance to restore health. Very few workmen with serious injuries can afford prolonged hospitalization, splints, appliances, physiotherapy, or necessary drugs, let alone the physician's fee. Such a patient, as a private patient, forces the surgeon to skimp, cut corners, often to the patient's disadvantage, because the patient cannot pay for necessary serv-

ices other than that of the physician. A second advantage is prompt payment for the services rendered. Admittedly, industrial fees are low, too low. The California Medical Association has appointed a committee to study the fee schedule with the objective of obtaining adjustments to the greater advantage of the physician.

These few examples will show, I hope, the need for industrial medicine and surgery to be of the highest type. An industrial physician, being proud of his results, should moreover record those results. When he bears witness in permanent disability ratings, he should be an unbiased skillful expert witness. The just interest of the patient must be his primary consideration, so that he may take pleasure in preventing avoidable injury or disease, as well as in restoring injured persons to economic self-sufficiency. And, first and last, the industrial physician should endeavor to preserve the patient-physician relationship which is seen in the best private medical practice.

350 Post Street.

INDUSTRIAL INJURIES: THEIR SURGICAL MANAGEMENT*

BENJAMIN M. FREES, M. D.
Los Angeles

IT has taken two wars and the great surge of industry to place industrial medicine on an equal footing with other specialties in the practice of the art and science of medicine. Twenty-five years ago, this field of medicine was frowned upon; but today it is one of the most important cogs in the Nation's war effort.

An industrial injury bespeaks a three-fold obligation on the part of the physician, namely, to the patient, to the employer, and to the insurance company. The industrial patient is entitled to as high a standard of medical and surgical care as is the patient in private practice. The employer expects efficient treatment of the patient so that the time loss may be as small as possible. The insurance company pays the bills, and the physician's services as to treatment, expense, length of disability and permanent disability are a matter of record to stand in direct comparison with others in this field.

To fulfill these obligations the physician must have the proper mechanical equipment for the surgical management of injuries, and he must maintain systematic records and reports.

SURGICAL CARE PROPER

Minor injuries to soft tissues.—Treatment of these injuries, which constitute a majority of the injuries sustained in industry, is important because too often infection develops from lack of proper care of minor injuries. The wound must

* Abstract of address presented at the Institutes on Wartime Industrial Health in San Diego, Inglewood, Glendale, Huntington Park, on August 26-28, 1942.

be cleansed thoroughly of any foreign material. Hydrogen peroxide, being an oxidizing agent, has certain advantages. This should be followed by some antiseptic such as merthiolate, mercurochrome, or mecrestin. Iodine is not one of the antiseptics of choice.

Wounds containing small foreign bodies.—Judgment must be exercised as to whether the foreign body be left alone. If deep, small, and not involving major structures, particularly joint surfaces and associated with only a puncture wound, we say, *leave it alone*. If superficial and easily accessible, especially in open wounds, one should attempt its removal, but no long, extensive exploration should be performed in office treatment. Patients having wounds in which foreign objects that should be removed are deeply imbedded had best be hospitalized.

Antitetanus serum for open wounds.—The administration of antitetanus serum to all patients having open wounds is still controversial, but until medicolegal opinion changes, the serum should be given to the majority of such patients. Giving the serum without a skin test should be condemned.

Major injuries to soft tissues.—These comprise one of the most important groups of injuries. The treatment consists in thorough débridement, followed by irrigation with a cleansing solution. A simple puncture wound may be a major injury; as for example, a puncture wound over the volar aspect of the wrist which may sever a nerve or an important tendon and go unrecognized. Tendon and nerve repair is one of the most important procedures in industrial surgery, but certainly has no place as an office procedure.

Surgical repair of tendons and nerves.—Very special equipment is required, and time is an important factor. If surgical repair is not possible within a few hours, the wound must be allowed to heal, and subsequent surgery done several weeks later.

Injuries to the abdomen.—It is especially important to differentiate between intra- and extra-peritoneal lesions. Early diagnosis is important.

Brain injuries.—These injuries are associated with concussion and contusions, with or without skull fracture, and diagnostically fall into operative or nonoperative cases. Depressions should be elevated. Prognosis, as well as treatment, should be conservative, since too early ambulatory convalescence may prolong the disability.

Hernia.—The physician frequently must pass on the compensability of hernias.

Surgical care versus injections.—A few years ago, this question was a paramount issue, but now appears to have been decided largely in favor of true mechanical repair by surgical procedure.

Eye injuries.—Foreign bodies on the conjunctiva are readily handled, but foreign bodies on the cornea require more serious consideration. A foreign body outside the line of vision can be readily removed by the average industrial surgeon, but foreign bodies in the line of vision

should be cared for by competent eye specialists.

Burns.—Treatment of burns is one of the most controversial subjects before the profession today. In major burns, the patient as a whole comes first in the treatment. Shock is combated with morphine and the intravenous injection of blood plasma. In the treatment of the wound, there are two generally accepted methods of treatment, namely, the closed method and the open method.

Back injuries.—Low backache is still unquarable diagnostically and therapeutically. There apparently is no clinical sign, symptom, or special test, and no combination of these, which can be reliably considered as diagnostic of either the area or type of causative lesion. The differentiation is probably almost entirely of academic interest. If intra-spinal, osseous, neoplastic, and remote causes are eliminated, the remaining 90 per cent of cases of low back and sciatic pain will be found to be muscular, intramuscular, articular, or ligamentous in origin. Of these, regardless of the exact type or area of the causative lesion, 90 per cent will be relieved by identical conservative therapeutic measures, such as rest, strapping, diathermy, massage, and the like. Indiscriminate acceptance of the nucleus pulposa lesion as the cause of low back pain is to be guarded against.

Fractures.—Each fracture presents its own problem and must be handled as such. No fixed method can be outlined for each fracture. Early open reduction and internal fixation are gaining more advocates. With the use of sulfanilamide and finer techniques, results have improved.

Skin lesions.—No other type of cases present the same degree of difficulty in disposition. Early consultation with a skin specialist is recommended.

In conclusion, the importance and indispensability of the industrial nurse should be emphasized. A successful industrial nurse must have a wider scope of training and a more peculiar sense of understanding in handling men and women than any other type of nurse. And I would further emphasize: surround yourself with the best possible consulting staff of specialists that are available in your locality, so that you may avoid some of the pitfalls encountered in the main classes of injuries I have described, and so that you may please all three, the patient, the employer, and the insurance company.

947 West Eighth Street.

MEDICAL EPONYM

Profeta's Law

This law was enunciated by Dr. Giuseppe Profeta (1840-1910), of Palermo, in an article, "Sulla Sifilide per Allattamento [Syphilis from Nursing]," that appeared in *Lo Sperimentale* (IV series 15:328-338 and 339-418, 1865). A portion of the translation follows:

"Thus, the healthy child born of a syphilitic mother may with impunity take the breast of its own mother or that of a syphilitic nurse, and neither the milk nor the presence of infectious lesions on the breast of the mother or the wet nurse is capable of transmitting the disease.—R. W. B., in *New England Journal of Medicine*.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL BUSINESS

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION: MINUTES

Minutes of the Three Hundred Fifth (305th) Meeting of the Council of the California Medical Association*

Meeting was called to order in room 404 of the Jonathan Club at Los Angeles, on Sunday, September 13, 1942, at 10:00 A.M., Chairman Philip K. Gilman, presiding.

1. Roll Call:

Present: Chairman Philip K. Gilman, and Councilors William R. Molony, Sr., Henry S. Rogers, Lowell S. Goin, E. Earl Moody, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Louis A. Packard, Axccl E. Anderson, R. Stanley Kneeshaw, Frank R. Makinson, Frank A. MacDonald, Calvert L. Emmons, John W. Cline, John W. Green, Edwin L. Bruck, Donald Cass, and George H. Kress, Secretary-Treasurer.

Absent: President-Elect Karl L. Schaupp.

Present by invitation: E. Vincent Askey, Vice-Speaker; Dwight H. Murray, Chairman of Committee on Public Policy and Legislation; Edward M. Pallette, Procurement and Assignment Service; A. E. Larsen, Secretary, California Physicians' Service; John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate; Ben Read, Secretary, Public Health League; Mr. Nicola Giulii, and Mr. Walter Swanson.

2. Minutes:

Minutes of the following meetings of the Council and the Executive Committee were approved:

(a) Council Meetings: 300th meeting, May 3, 1942; 301st meeting, May 4, 1942; 302nd meeting, May 5, 1942; 303rd meeting, May 6, 1942; and 304th meeting, May 7, 1942.

(Abstracts were printed in C. & W. M., June, 1942, on pages 357-360.)

(b) Executive Committee Meetings: Organization (176th) meeting, May 7, 1942; meeting, July 11, 1942. (Abstract in August C. & W. M., page 145); meeting of September 8, 1942.

3. Membership:

(a) A report of membership was submitted and placed on file. Total number of members who have paid 1942 dues is 6926, this group including 794 members in military service whose dues were paid from the General Fund of the C.M.A. Total number of new members included in the above, 398.

(b) A list of last year's members to a total of 1481, whose 1942 dues have been paid subsequent to April 1, 1942, was submitted, the membership of such members having automatically lapsed on April 1, 1942. On motion duly made and seconded, their active membership for the year 1942 was reestablished.

(c) Upon motion duly made and seconded, it was voted that Retired Membership be granted to two members whose applications were received in duly accredited

† For complete roster of officers, see advertising pages 2, 4, and 6.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

form from their respective component county societies:

Joseph A. Champion, San Bernardino County.

Will R. Manning, Ventura County.

4. Financial:

(a) Executive Secretary Hunton made reports of finance as follows:

Report of finances as of September 12, 1942; and report of income and expenditures for August and for 8 months ending August 31, 1942.

(b) Concerning members who have been in military service and who have returned to civilian practice, it was voted that such members should again become paying members, the dues being prorated, with exemption for the military service periods.

(c) For several years, the California Medical Association has granted subsidies of twenty-five cents per active member to the Lane Medical Library of San Francisco and to the Barlow Medical Library of Los Angeles; these two institutions in return maintaining special packet service and similar activities for members of the Association.

It was voted that for the year 1942 the twenty-five cent payment should be made for only such active members as have themselves paid their annual dues. There will be no library allocations for members in military service, whose dues are paid from the General Fund of the California Medical Association.

(d) Concerning C.P.S. or other coverage for clerical employees of the central C.M.A. office, Council Chairman Gilman was empowered to appoint a committee to report thereon.

(e) The action of Council Chairman Gilman in accepting the advice of the Legal Counsel that court action be not commenced to recover federal deficiency tax assessments paid in years 1936-1939, inclusive, was approved.

5. Resignations and Appointments:

Report was made concerning resignations and tentative appointments made by the Council Chairman. On motion made and seconded, the same were approved:

(a) Editorial Board:

Resigned from Pathology: Dr. David A. Wood, San Francisco.

Appointed to fill vacancy: Dr. Alvin Cox, San Francisco.

(b) Special Committee on Industrial Fee Table:

Resigned: Dr. Morton R. Gibbons, San Francisco.

Appointed to fill vacancy: Dr. Donald Cass, Los Angeles.

(c) Committee on Postgraduate Activities:

Resigned: Dr. Francis Rochex, San Francisco.

Appointed to fill vacancy: Dr. Dan Delprat, San Francisco.

(d) Technical Advisory Committee for Nutrition of Workers in War and Related Industries:

Appointed: Dr. John V. Barrow, Los Angeles.

6. California Physicians' Service:

(A) The Council gave consideration to a letter dated September 8, 1942, received from California Physicians' Service, through its Secretary, Doctor A. E. Larsen. Action on the items contained therein was as follows:

(a) Concerning the possibility of California Physicians' Service making a contract with the National Housing Agency to render medical care to war workers residing in Federal Housing Projects, the state-wide plan proposed by C.P.S. was given approval, through adoption by the Council of the resolution on the same subject recommended by the Executive Committee of the California Medical Association at its meeting of September 8, 1942:

Resolved, That the C.M.A. Executive Committee believes that it is to the best interests of present and future medical practice in California, both as regards physicians now in civilian practice and to colleagues in the armed services, that the provision of medical and collateral service designed for citizens attached to Federal Housing projects be carried through in harmony with a state-wide plan, as laid down in principles that have been enunciated by the House of Delegates of the California Medical Association; it being stipulated that the state-wide plan shall provide for fullest possible control and cooperation by local county medical societies and members, in carrying through such medical service in satisfactory manner.

(b) Report was made upon the development of the C.P.S. program to spread the rural health program, which, in its beginning in the year 1941, had centered in Butte, Sonoma, and Monterey Counties, and which it was now proposed should be placed upon a state-wide basis. It was stated that C.P.S. had informed its professional members in regard to the extension of the plan. The C.M.A. Council gave its approval to the continuation of this work, and to the extension of scope that would place it on a possible state-wide basis.

(c) The plan of the C.P.S. to employ a limited number of refugee physicians in the Federal Housing Projects, placing such physicians on a salary basis, but stipulating that their full time should be given to their salary work, with no permission to engage in private practice in the communities, was discussed. The Council gave its approval to the plan as above outlined.

(B) A situation which had arisen in Santa Clara County, in connection with a large wartime industrial plant, was explained by Officers of C.P.S. and Councilor Kneeshaw of the 5th Councilor District.

It was brought out that this industrial enterprise had to do with production of war materials essential to the welfare of our Country; and under existing wage conditions, a larger number of employees than usual were somewhat above the \$3,000 income ceiling limitation. It was stated that the industrial management was kindly disposed to California Physicians' Service and was willing to supplement the regulation monthly prepayments by subsidies, provided arrangements could be made that would insure prompt first-aid care, etc. There would be no attempt to infringe upon professional work coming under the California Industrial Accident Act; it being stated further, that the commercial insurance carrier covering the industrial risks was willing that patients requiring care under the Industrial Accident Act should be cared for by physicians and surgeons in Santa Clara County, where they could receive prompt attention, instead of sending them to one of the more distant metropolitan centers for professional aid.

After considerable discussion, on motion by Cline, seconded by MacDonald, it was voted it be the policy, as regards this and similar cases that might arise, contracts should have safeguarding provisions concerning industrial and nonindustrial professional work rendered by salaried physicians. Further, that the contracts should be made with employee groups rather than with the owners of the establishments; and that when salaried physicians were placed in such plants by C.P.S., the delineation of duties should be clearly defined.

(C) Report was made that a goodly number of members of the Alameda County Medical Association who had resigned as professional members of California Physicians' Service had reconsidered their resignations and had withdrawn the same, and that the conditions in that County were much improved.

(D) The Council considered the information that had come to it that the hospital organization, "Hospital Service of California," with headquarters in the San Francisco Bay region, contemplated the extension of its hospitalization activities by offering medical or surgical

service indemnity contracts.

After discussion, on motion by Cline, duly seconded, it was voted that the Council call the attention of Hospital Service of California to the governing rules outlined in Minute No. 7947 of the meeting of November 2, 1935, at which time a special committee, consisting of Doctors C. A. Dukes and Daniel Crosby, brought in a report that was approved; Paragraph No. 1 under the governing rules being as follows:

"1. Hospital services that are provided by nonprofit corporations shall not include medical services or medical care as these have been defined by official action of the House of Delegates of the American Medical Association."

The Council voted that Hospital Service of California be reminded that the original approval of Hospital Service of California by the California Medical Association was conditioned on the governing rules referred to. Further, that Hospital Service of California be informed that the proposed medical service contracts by that organization would be contrary to the conditions under which approval had been given by the California Medical Association; and that if such medical service contracts were written by Hospital Service of California, then the Council of the California Medical Association would have no other option than to withdraw its approval of the hospitalization organization, "Hospital Service of California."

(E) Discussion took place concerning the increasing number of employees who were formerly in the lower income groups, but who under the existing war-time conditions were receiving salaries in excess of the \$3,000 ceiling.

The importance of having the medical profession keep in step with other agencies throughout the United States in promotion of wartime efficiency and output was stressed, it being stated that, in all probability, at the end of the duration, the unusual economic conditions now existing, in which many incomes are larger, but living expenses also greater, would probably rectify themselves. In the meantime, it seemed desirable that California Physicians' Service should be permitted to provide service for certain income groups, with full understanding, however, that any variations concerning income ceilings, etc., should be looked upon as of a temporary nature.

It was felt that it would expedite the work of C.P.S. if a general policy could be outlined so that the C.P.S. could proceed without bringing every special incidence for specific action by the C.M.A. Council.

Upon motion by Cline, seconded by Molony, the Council voted that, as a general policy concerning large groups of employees, the \$3,000 wage ceiling was desirable, but that California Physicians' Service should be permitted to make contracts even though some employees were above the \$3,000 ceiling; provided, however, that when the number of such employees exceeded ten per cent of the whole, then the proposed contract should be referred to the Council for action.

(F) Other problems dealing with shipyards in the northern and southern sections of the State were discussed, but no definite action was taken thereon, it being felt that the principles previously considered by the Council would cover most conditions as they might arise.

7. Basic Science Initiative:

(a) Report was made concerning the Basic Science Initiative. Mr. Read, of the Public Health League, outlined the steps that organization had taken and spoke of procedure plans for the future.

Mr. Read stated that to date no influential lay group had opposed the Basic Science Initiative. Further, that steps had been taken to interest organizations of both

men and women in the work ahead and that literature, radio, and speaking bureaus would be utilized to keep the proposed law properly before the public.

For the California Medical Association, the general supervision of the Basic Science campaign will be under the care of a steering committee consisting of Doctors John W. Cline of San Francisco; Frank R. Makinson of Oakland, and John W. Crossan of Los Angeles.

8. Physicians' Benevolence Fund:

(a) Doctor Axel E. Anderson made a report on behalf of the Physicians' Benevolence Committee of the California Medical Association, outlining its work to date, explaining some of its difficulties, and indicating some of its hopes for the future.

9. American Medical Association:

(a) The Annual Session of the American Medical Association, which by action of the House of Delegates of the American Medical Association two years ago, was scheduled to be held in San Francisco in the year 1943 on date to be selected by the A.M.A. Board of Trustees, was then taken up for consideration.

Doctor Edward M. Pallette, newly-elected Trustee of the American Medical Association, who was present by invitation, outlined the problem to be considered by the A.M.A. Trustees, in relation to the San Francisco meeting in 1943.

A full discussion ensued in which many Councilors took part. Such items as transportation facilities, military possibilities and needs, room allocations in the Civic Auditorium buildings, funds already appropriated by the City of San Francisco, and other related matters were fully covered.

After further discussion, upon motion by Councilor Cline, President of the San Francisco County Medical Society, the following resolution was unanimously adopted:

Resolved, By the Council of the California Medical Association, in the event the Board of Trustees of the American Medical Association decides to call no general scientific meetings in the year 1943, limiting the Annual Session to meetings of the A.M.A. House of Delegates, that under such conditions the California Medical Association will have no special interest in the place of meeting; and be it further

Resolved, By the Council of the California Medical Association, in case the American Medical Association proceeds in accordance with past custom, to hold a regular annual session, with section meetings, scientific and technical exhibits; that under such conditions, next year's annual session should be held in San Francisco in accordance with the action taken by the A.M.A. House of Delegates, it being agreed that in case, later on, military circumstances should arise necessitating other arrangements, the A.M.A. Board of Trustees could always take appropriate action.

(b) Discussion was had concerning per diems for Delegates of the California Medical Association to sessions of the House of Delegates of the American Medical Association. Although the by-laws do not classify such delegates as officers, it was felt that they were acting in the same capacity as officers of the California Medical Association, and it was agreed that they should not be put to too great a money loss in attendance at these meetings. It was pointed out that it was almost universal custom of state medical associations to cover the expenses of their delegates. Upon motion by Moody, seconded by Packard, it was voted that the regulation per diem for officers should be paid to C.M.A. Delegates to cover a time period of attendance and return by the most direct route. First class rail transportation and lower berth also to be allowed.

10. Rebate Resolutions:

(a) Attention of the Council was called to a letter received from the American Medical Association, through

its Secretary, Doctor Olin West, regarding resolutions adopted by the House of Delegates of the A.M.A. concerning rebates, the same having been submitted by the C.M.A. House of Delegates. (Reference: August, 1942 issue of CALIFORNIA AND WESTERN MEDICINE, pages 151-153.)

11. Prescription Blank Proposal:

A communication from a banknote company regarding prescription blanks was considered.

It was voted that the California Medical Association could not become a party to a plan that would promote any type of advertising.

12. Fee Table of the California Industrial Accident Commission:

Report was made by Councilor Cass for the Special Committee on Fee Tables (consisting of Doctors Cass, MacDonald, and Hoag), concerning plans to present to the Industrial Accident Commission proposals for increase in fee-table rates for professional services rendered to citizens coming under the Industrial Accident Act.

Upon motion duly made and seconded, a special committee consisting of Council Chairman Gilman, Legal Counsel Peart, and Executive Secretary Hunton was appointed to cooperate with the Special Committee on Fee Table, and to have power to secure additional aid if necessary, in the attainment of the desired objectives.

13. Procurement and Assignment Service:

Doctor Edward M. Pallette of Los Angeles, and Chairman of Procurement and Assignment for the fourteen southern counties of California, was called upon for a report concerning the procurement work. Doctor Pallette spoke of the present situation, stating that in some of the rural communities, owing to the limited number of physicians remaining, no further procurements could be taken therefrom, and that the filling of California's quota of something like 2800 physicians by December 31, 1942, now must come largely from the metropolitan areas.

14. Legal Report:

Legal Counsel Peart reported on several interesting medical-legal cases.

As regards services recently rendered by Messrs Maurice Rankin and Louis O'Neal in San Jose, motion was made by Anderson, seconded by Kneeshaw, that a vote of thanks be tendered these gentlemen for their generous cooperation.

15. Annual Joint Conference of County Society Secretaries and C.M.A. Officers:

Association Secretary Kress called attention to the annual joint conference of County Society Secretaries and C.M.A. Officers, and Chairmen of Standing and Special Committees of the State Association.

After discussion, it was voted that the Council should hold its next meeting on Saturday, February 27, 1943, and that the annual joint conference with County Society Secretaries should be held on Sunday, February 28, 1943.

16. Proposed School for Medical Record Librarians:

A letter received from Councilor Makinson concerning a proposed school, "School for Medical Record Librarians" was read and referred to the Standing Committee on Hospitals, Dispensaries, and Clinics (J. Norman O'Neill, Benjamin W. Black, and Walter Rapaport) for report and recommendations.

17. Resignation of Councilor Louis A. Packard:

Councilor Louis A. Packard presented his resignation as Councilor for the Third Councilor District, stating that he would be away from the State for some time.

Upon motion duly made and seconded, the resignation was accepted with regret.

The Council voted that Council Chairman Gilman should appoint a committee to submit names for a successor to Doctor Packard, whose term expires in 1943. Council Chairman Gilman stated he would ask the Presidents of the county societies in the Third Councilor District to send such names to him, these then to be submitted to the Council.

18. The Present Complexion of State Boards:

In an informal discussion, the importance of keeping in touch with the State Board of Public Health and the State Board of Medical Examiners was brought out, attention being called to the fact that these Boards have great authority and influence over matters concerned with the public health and the best interests of medical practice. It was felt that members of the medical profession should remain in touch with the members of such Boards, and with related governing bodies, in order that standards to which the medical profession is committed should be kept constantly in mind.

19. California State Chamber of Commerce:

Upon motion by Dewey, duly seconded it was voted that the California State Chamber of Commerce be granted a donation of \$7000.

20. Membership Requirements for Physicians Seeking Admission to Membership in Component County Units of the California Medical Association:

Discussion was had concerning the large number of physicians in California who are licensed and who have not secured citizenship.

It was voted that the Association Secretary communicate with the component county medical societies informing them that the Council submitted the suggestion that each component county unit might well consider whether it would not be desirable to demand citizenship as one of the requirements for membership.

21. C.M.A. Annual Session in 1943:

It was agreed that plans previously outlined for next year's annual session of the California Medical Association to be held at Del Monte, should be carried through, the C.M.A. Executive Committee or Council being in position to change the same should conditions so warrant.

2. Nurses' Unions in California Hospitals:

Informative discussion took place concerning the nursing situation in the San Jose Hospital and in connection with a recent Nurses' Union and a strike of hospital nurses. No action was taken thereon.

23. Adjournment:

Upon motion duly made and seconded, it was voted to adjourn, the Council to meet again on Saturday, February 27, 1943, unless a special meeting is called prior thereto.

PHILIP K. GILMAN, *Chairman*,
GEORGE H. KRESS, *Secretary*.

Abstract of Minutes: California Medical Association Executive Committee*

Minutes of Meeting of the Executive Committee of the California Medical Association, Held in San Francisco and Vallejo, Tuesday, September 8, 1942

A meeting of the C.M.A. Executive Committee was

* Full minutes of the Executive Committee meeting have been mailed to all councilors, and copies are also available for inspection in the central office of the Association.

called to order in the office of the California Medical Association, 450 Sutter Street, San Francisco, on Tuesday, September 8, 1942, at 5:00 p.m.

1. Roll Call:

Present were Doctors William R. Molony, Sr., Karl L. Schaupp, and George H. Kress of the Executive Committee. Also Doctor A. E. Larsen of California Physicians' Service, and Mr. John Hunton, Executive Secretary of the California Medical Association.

Later, at Vallejo, Past-President Henry S. Rogers joined the Committee, and a quorum being present at the time, a formal meeting was held in the Casa Del Vallejo. In Vallejo, Councilor John W. Green was also present.

2. Consideration of Medical Service to Citizens in Housing Projects:

A general discussion took place concerning problems connected with provision of medical service and hospitalization for the hundreds of citizens in Solano County who are in residence in federal housing project units.

Doctor A. E. Larsen outlined the status of negotiations with Federal Housing Authorities, with special relation to a state-wide plan that would permit the Federal Housing Authorities to negotiate with California Physicians' Service as a State agency that could provide medical service and hospitalization to citizens who are resident in many of the housing projects that have been brought into existence in California in order to better supply products needed by the Armed Forces of the United States.

In the discussion which followed, it was emphasized that, while California Physicians' Service would be the central agency in California through which certain plans could be put in operation, C.P.S., in entering any project located in California, would make it a rule to always confer with the local county medical society and local medical profession in an effort to work out details of procedure that would be satisfactory to the local profession; and the local county society, and local profession to be permitted to have as much control and authority as possible.

After further discussion, the following motion made by Dr. Schaupp, seconded by Dr. Molony, was put by Executive Committee Chairman Rogers:

Resolved, That the C.M.A. Executive Committee believes that it is to the best interests of present and future medical practice in California, both as regards physicians now in civilian practice and to colleagues in the armed services, that the provision of medical and collateral service, designed for citizens attached to Federal Housing projects, be carried through in harmony with a state-wide plan, as laid down in principles that have been enunciated by the House of Delegates of the California Medical Association; it being stipulated that the state-wide plan shall provide the fullest possible control and coöperation by local county medical societies and members, in carrying through such medical service in satisfactory manner.

The motion was unanimously approved.

It was also agreed that Executive Committee Chairman, Henry S. Rogers, with the permission of President Snoddy of the Solano County Medical Society, should introduce the speakers who would present the entire subject to the members of the Solano County Medical Society; it being agreed that the first talk should be made by C.M.A. President, William R. Molony, Sr., the second by Doctor A. E. Larsen, and the third by President-Elect Karl L. Schaupp, the subject then to be thrown open to general discussion. This was done.

(Note. At the meeting of the Solano County Medical Society the above procedure was carried through Doctor John W. Green of Solano County making a motion that the Solano County Medical Society accept and give its approval to the above resolution as adopted by the C.M.A. Executive Committee. Doctor Larsen, of California Physi-

cians' Service, informed the members of the Solano County Medical Society that, as the representative of C.P.S., he would make every effort to carry through the plans as submitted in manner to be agreeable to the Solano County Medical Society. After free discussion, President Snoddy of Solano County put the question, no negative votes being cast.)

HENRY S. ROGERS, *Chairman*,
GEORGE H. KRESS, *Secretary*.

Meeting of A.M.A. in San Francisco, in 1943, Cancelled

(COPY)

AMERICAN MEDICAL ASSOCIATION

Olin West, M.D., *Secretary and General Manager*
535 North Dearborn Street, Chicago

September 22, 1942.

Dr. George H. Kress, Secretary,
California Medical Association,
450 Sutter Street,
San Francisco, California.
Dear Doctor Kress:

(1) *Cancellation of San Francisco Session in 1943*:*

After prolonged and intensive consideration, the Board of Trustees of the American Medical Association has come to the conclusion that the annual session of the Association scheduled to be held in San Francisco in 1943 should be cancelled. An official announcement to that effect will appear in the *Journal* of the Medical Association. This decision of the Board of Trustees was made after securing the best available official information and after thorough consideration of the many factors involved.

(2) *A. M. A. House of Delegates Will Meet in Chicago in 1943:*

An official meeting of the House of Delegates of the American Medical Association will be held in Chicago at a time to be announced.

(3) *Annual Conferences of State Association Secretaries and Editors, in Chicago, Nov. 20-21, 1942:*

The Annual Conference of Secretaries of Constituent State Medical Associations will be held at the Association's offices in Chicago on November 20 and 21, for the purpose of discussing existing problems and problems that may develop as the result of the intensification of the war program. Your kindness will be greatly appreciated if you will suggest topics for the Conference program. It is the desire of the Board of Trustees and of other officers of the American Medical Association that the program pertain to matters of important common interest and it is hoped that the papers and discussions presented before the Conference can be made as helpful as possible to secretaries, editors and other officials of the constituent state medical association. . . .

With all good wishes, I am,

Sincerely yours,

OLIN WEST.

What an exciting super-tomorrow it will be! Americans are today making the greatest scientific developments in our history. That is a promise of new levels of employment, industrial activity and human happiness.—
Clarence Francis.

These are the times that try men's souls; the Summer Soldier and the Sunshine Patriot will, in this crisis, shrink from the service of his country but he that stands it now deserves the love and thanks of Man and Woman.
—*Thomas Paine.*

* Subheads inserted by C. and W. M.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals: For Colleagues in Military Service

In the September issue of C. and W. M., on page 169, appeared editorial comment on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

This notice will appear in this department every month.

If you have not read the editorial outline of the plan in the September issue, you are urged to do so.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 534 South Westlake, Los Angeles, California.

If more convenient, you can send journals to: C. M. A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California.

Continued coöperation by component county medical societies, and by medical staffs of hospitals (through officers, volunteer or other committees) is requested.

Letter from Harold A. Fletcher, M. D., Chairman of California Procurement and Assignment Service:
Re Personal Interviews and Other Work
(COPY)

Office for Emergency Management

OFFICES OF DEFENSE HEALTH AND WELFARE SERVICES

Director: Federal Security Administrator
Washington, D. C.

San Francisco Office, Room 1435, 450 Sutter Street
San Francisco, California, Sept. 22, 1942.

Dear Doctor Kress:

Until about two weeks ago I, as Chairman for the Procurement and Assignment Service for Physicians for California, had endeavored to hold as many personal interviews with physicians as possible. This meant giving

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north to the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Roster of county chairman on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (FEderal 1953).

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

a tremendous amount of time to personal interviews. As you know, the Chairman for Procurement and Assignment is not paid by the Government and receives no compensation from any source. The position should be a full time position as the importance of this program demands a tremendous amount of work, both on the part of the Chairman as well as on the part of the County Committees of Procurement and Assignment. I have been very glad to give unsparingly of my time and energy to this work and am continuing to do so. For long intervals it was necessary practically to give up my private practice and to devote from 14 to 16 hours a day solely to the work of Procurement and Assignment.

Until recently we have had very little clerical help furnished by the Government. More recently, since Procurement and Assignment has come under the office of War Manpower, we have received more help in the nature of secretarial and stenographic services. Even now, however, we are very much understaffed but are hoping to obtain further help.

In view of the above conditions, I have been forced to discontinue personal interviews with either local physicians or physicians from other counties. There just has not been the time to hold these personal interviews. The tremendous amount of time and energy which I have had to give to this work has created too great a strain to carry on this practice. I feel that the possible publication of this letter in the JOURNAL may lead to an understanding of my position and the reason for not holding personal interviews on the part of physicians who might naturally feel a personal interview in their case most necessary.

I wish to again express thanks and appreciation of the wonderful coöperation I have had from the office of the California State Medical Association. Without the help which has been so generously given me I could not have carried this work on at all. Mr. John Hunton has been able to take over a great deal of executive work, particularly recently, and is still continuing to hold personal interviews with physicians who I have not had the time to interview myself for the reasons stated above.

With my kindest personal regards, I remain,

Sincerely yours,

(Signed) HAROLD A. FLETCHER, M. D.,
California State Chairman for Physicians,
Procurement and Assignment Service.

Northern California Committee of Procurement and Assignment

Office for Emergency Management

OFFICE OF DEFENSE HEALTH AND WELFARE SERVICES

Director FEDERAL SECURITY ADMINISTRATOR
Procurement and Assignment Service

Board: Frank H. Lahey, M. D., Chairman
Harvey B. Stone, M. D. Harold S. Diehl, M. D.
James E. Paullin, M. D. C. Willard Camalier, D.D.S.
Washington, D. C.

San Francisco Office, Room 1435, 450 Sutter Street
San Francisco, Calif., Sept. 22, 1942.

To the Editor:—I feel that it might be advisable for you to publish the names of the Northern California Committee of Procurement and Assignment which I appointed some time ago. I have long felt that such a committee was advisable but had originally been told that aside from county committees the various state chairmen were not to appoint a central state committee. Since the appointment of this committee I have recently received directions and authorization to form such a committee. The following is the committee of Procurement and Assignment for Northern California:

George E. Ebright, M.D., Vice-Chairman, 384 Post Street, San Francisco.

Albert M. Meads, M.D., 251 Moss Avenue, Oakland.
R. Stanley Kneeshaw, M.D., Medical Dental Building, San Jose.

Henry S. Rogers, M.D., Petaluma.

Clinton D. Collins, M.D., 2607 Fresno Street, Fresno.

With my kindest personal regards, I remain,

Sincerely yours,

HAROLD A. FLETCHER, M.D.,
*California State Chairman for Physicians,
Procurement and Assignment Service.*

Southern California Committee on Procurement and Assignment

Office for Emergency Management

OFFICE OF DEFENSE HEALTH AND WELFARE SERVICES

Procurement and Assignment Service

1930 Wilshire Boulevard

Los Angeles, September 25, 1942.

To the Editor:—My committee for Southern California on Procurement and Assignment Service is as follows:

C. G. Toland, M.D., 1925 Wilshire Boulevard, Los Angeles.

William H. Kiger, M.D., 1925 Wilshire Boulevard, Los Angeles.

William R. Molony, M.D., 1930 Wilshire Boulevard, Los Angeles.

Charles W. Anderson, M.D., Bishop.

John L. Parker, M.D., 120 South 6th Street, Brawley.

William H. Moore, M.D., Habersfelde Building, Bakersfield.

Lionel W. Sorenson, M.D., Corcoran.

H. G. Huffman, M.D., 215 South Main, Santa Ana.

William W. Roblee, M.D., 3616 Main Street, Riverside.

Emmett L. Tisinger, M.D., 575 Fifth Street, San Bernardino.

Bryant Simpson, M.D., Medico-Dental Building, San Diego.

Ira B. Bartle, M.D., 722 Marsh Street, San Luis Obispo.

Hugh F. Freidell, M.D., 1515 State Street, Santa Barbara.

A. W. Preston, M.D., 222 West Willow, Visalia.

Grundy C. Coffey, M.D., 23 South California Street, Ventura.

Cordially yours,

(Signed) EDWARD M. PALLETTE, M.D.,
*Vice-Chairman, State of California,
Procurement and Assignment Service.*

On: Commissions to Physicians

Office for Emergency Management

WAR MANPOWER COMMISSION

*Procurement and Assignment Service for Physicians,
Dentists, and Veterinarians*

Washington, D. C., September 9, 1942.

Dr. Harold A. Fletcher,
Rm. 1435, 450 Sutter St.,
San Francisco, Calif.

Dear Dr. Fletcher:

It is important that all Corps and State Chairmen acquaint themselves with the new regulations concerning the granting of commissions to physicians, as detailed in this release from the Surgeon General's Office.

It is suggested to State Chairmen that if this information has not been published in your State Journal

you submit it to the editor for publication in the next issue.

Sincerely yours,

(Signed) FRANK H. LAHEY, M.D., *Chairman.*

(COPY)

WAR DEPARTMENT

Services of Supply

Office of The Surgeon General

Washington

August 22, 1942.

The Surgeon General of the Army published detailed information concerning policies governing the initial appointment of physicians as medical officers on April 23, 1942. Necessary changes are given wide publicity, at his request, in order that the individual applicants, and all concerned in the procurement of medical officers, may know the status of such appointments.

The current military program provides for a definite number of position vacancies in the different grades. The number of such positions must necessarily determine the promotion of officers already on duty and, in addition, the appointment of new officers from civilian life. Such appointments are limited to qualified physicians required to fill the position vacancies for which no equally well qualified medical officers are available. Such positions calling for an increase in grade should be filled by promotion of those already in the service, insofar as possible, and not by new appointments.

If this policy is not followed, it would definitely penalize a large number of well qualified Lieutenants and Captains already on duty by blocking their promotions which have been earned by hard work. In view of these facts, it has been deemed necessary to raise the standards of training and experience for appointment in grades above that of First Lieutenant.

With this in view, the Surgeon General has announced the following policy which will govern action to be taken on all applications after September 15, 1942:

All appointments will be recommended in the grade of First Lieutenant with the following exceptions:

Captain:

1. Eligible applicants between the ages of 37 and 45 will be considered for appointment in the grade of Captain by reason of their age and general unclassified medical training and experience.

2. Below the age of 37 and above the age of 32, consideration for appointment in the grade of Captain will be given to applicants who meet all of the following minimum requirements:

a. Graduation from an approved medical school.

b. Internship of not less than one year, preferably of the rotating type.

c. Special training consisting of 3 years' residency in a recognized specialty.

d. An additional period of not less than 2 years of study and/or practice limited to the specialty.

3. Eligible applicants who previously held commissions in the grade of Captain in the Medical Corps (Regular Army, National Guard of the United States, or Officers Reserve Corps) may be considered for appointment in that grade provided they have not passed the age of 45 years.

Major:

1. Eligible applicants between the ages of 37 and 55 may be considered for appointment under the following conditions:

a. Graduation from an approved school.

b. Internship of not less than one year, preferably of the rotating type.

c. Special training consisting of 3 years' residency in a recognized specialty.

d. An additional period of not less than 7 years of study and/or practice limited to the specialty.

e. The existence of appropriate position vacancies.

f. Additional training of a special nature of value to the military service, in lieu of the above.

2. Applicants previously commissioned as Majors in the Medical Corps (Regular Army, National Guard of the United States, or Officers Reserve Corps) whose training and experience qualify them for appropriate assignments may be considered for appointment in the grade of Major provided they have not passed the age of 55.

Lieutenant Colonel and Colonel:

In view of the small number of assignment vacancies for individuals of such grade, and the large number of Reserve Officers of these grades who are being called to duty, such appointments will be limited. Wherever possible, promotion of qualified officers on duty will be utilized to fill the position vacancies.

* Much misunderstanding has arisen concerning recognition by Specialty Boards and membership in specialty groups. It will be noted that mention is not made of these in the preceding paragraphs. This is due to the variation in requirements of the different Boards and organizations. Membership and recognition are definite factors in determining the professional background of the individual, but are *not* the deciding factors, as so many physicians have been led to believe.

The action of the Grading Board, established by the Surgeon General in his office, is final in tendering initial appointments. Proper consideration must be given such factors as age, position vacancies, the functions of command, and original assignments. All questionable initial grades are decided by this Board. Due to the lack of time, no reconsideration can be given.

There are in the age group 24-45 more than a sufficient number of eligible, qualified physicians to meet the Medical Department requirements. It is upon this age group that the Congress has imposed a definite obligation of military service through the medium of the Selective Service Act. The physicians in this group are ones needed *now* for active duty. The requirements are immediate and imperative. Applicants beyond 45 years may be considered for appointment only if they possess special qualifications for assignment to positions appropriate to the grade of *Major* or above.

Selective Service Examinations and Coöperation of Component County Medical Societies

(COPY)

State of California

DIRECTOR OF SELECTIVE SERVICE

Plaza Building, Sacramento

September 7, 1942.

Dear Doctor Kress:

Just as every community is feeling a loss of Doctors into the Service, so the Selective Service finds itself in difficulty in some few spots in California—due to the fact that available medical personnel is becoming scarce.

It is most simple to understand that in those areas where men are not being satisfactorily processed in numbers, there is no delivery of the necessary manpower to fill our forces, for—the delivery of registrants to Induction Stations depends upon the smooth working of a team. This team consists of a Local Board, clerks of that Board, and the Examining Physicians of the Board. If any one of the three components of the team falls down, all fall. We experienced some failure in August, and I am pleased to tell you that the medical failure accounted for but a very small percentage of our loss. In other words, the close to 3000 medical men who are examining for us in California are accomplishing a "swell job"—even though some are doing it "the hard way."

It is this last fact that causes me to write. Although the "hard way" or "piecemeal" method of examining has accomplished our end (except for some few exceptions), our over-all survey discloses most surely that it will not hold up as our demands grow heavier. Unlimited numbers, however, may be processed in the simplest of manners, and without real effort, when a method of "line production" is established in any locality. A group properly organized around even but two Doctors—yes, even one—may handle hundreds of registrants in but one or two hours per week.

To advise all of our Examiners of the urgency of such 'grouping' the attached letter was sent to them last week. We feel that this problem of making certain that the medical portion of the team (upon which the production of an army depends) properly functions is so important that we should like this message re-run in CALIFORNIA AND WESTERN MEDICINE. We know that we can depend upon you to publish that letter in the next issue of the JOURNAL, and thus make certain of reaching not only our present Examiners, but also all of your mem-

bers whom we must consider as potential Selective Service Examiners.

A minute to study this last statement:—With the recent completion of organization for this work by one of the large component societies, we can state that most points in the State are now in good shape to "back the line." This organized effort must be complete. Therefore—now—through you and the officers of the Society, we are asking that every member of the C.M.A. who does not enter the service, be listed in a County Society pool; that such Doctors be made available for the work whenever they might be called upon to serve. The method of handling this problem in the Societies where the results have been excellent, has been as follows:—The Secretary or the Chairman of a Committee especially designated for this purpose, maintains a list of available Doctors (all of them, in several Societies) and that roster includes information which discloses upon which days or nights the particular Doctor is available. When any group loses a Doctor to the service, either the Selective Service Coördinator of the District or the Local Board or group of Boards concerned, calls upon the Secretary of the Local Society to supply an Examiner from the roster, so that the necessary numerical strength of the examining group is maintained.

We can make a most certain statement—if the Doctors will so organize for this work and will follow our suggestions in the accompanying letter, no one Doctor should be called upon for more than about two hours' work per week in this primary medical need. We say "primary" because, as "night" follows "day," so "no army" follows "no examining"—and—"no future 'American' Doctor" follows "no army."

It might seem to you as though our constant close association with the Selective Service medical problem has made us look upon this specific picture in a manner which is out of proportion to the entire medical picture. But you recognize that the discussion of this problem as above, when we called the problem a primary one is most correct. This becomes more so when you consider that the numbers to be delivered by Selective Service grow increasingly greater and greater and when you are advised that short'y we deliver not only to the army, but to all of the services.

May I again express my sincere thanks to you and to the organized profession for your continued and constant coöperation.

Very truly yours,

(Signed) BERT S. THOMAS,
Lt. Colonel, M.C., U.S.A.,
Chief, Medical Division.

1 1 1

(COPY)

STATE HEADQUARTERS SELECTIVE SERVICE

STATE OF CALIFORNIA

Plaza Building, Sacramento

September 1, 1942.

To Doctors:

"Line Production"—Not Piecemeal—Is the Present
Selective Service Medical Need

During the two years of our medical association in the medical examining of the Selective Service—a splendid "job" has been accomplished by you in California. Thank you most sincerely.

We chat for a few minutes, now—on the work to come. We will constantly have Doctors leaving for the service. We shall be constantly called upon to deliver more and more to you for Selective Service examinations. This means that, in those localities where Doctors have not followed our constant admonition to organize in

groups for this examining, those Doctors and Local Boards will be unduly burdened and will not be able to meet the needs of the services.

Wherever Doctors have been organized for group examining, the work is proceeding splendidly. We can report to you that, in all large centers, such organization has been accomplished and no matter how many Doctors are drawn from the community, the Selective Service load will be carried.

We worry a bit about some smaller centers where Doctors still insist upon taking the 20 or 30 per week and examine this number in their own offices. When we invite your attention to the fact that a few doctors (3, 4 or 5), together with clerical help, and, possibly, a nurse or two to aid them, spending a few hours one day or night per week *can process* 300 to 400 in that time—we give you the entire solution to the problem. The present "screening" examination (plus the taking of blood) is such that the number just stated *can* be processed in the time stated.

We ask that any Doctors who are still handling 20 or 30 registrants per week in their own offices contact their Local Board, and we are asking the Local Board to contact you—so that *group examining* and only Group Examining will be the plan of action in California (except for a few stragglers who might have to be sent to offices upon rare occasions, and except for other necessary action in isolated localities). Please make these Local Board contacts immediately—for, the load will grow larger and the number of Doctors available will become less.

Thank you kindly for your splendid work and may it continue to be pleasant, nonburdensome, and productive of an armed force second to none on earth. We repeat—our objective may be met by proper organization and "grouping" as outlined above.

(Signed) K. H. LEITCH,
State Director of Selective Service.

Lieut. Col. Sam F. Seeley Detached from Procurement and Assignment Service

Under Medicine and the War in this issue of *The Journal*, appears an announcement of the detachment of Lieut. Col. Sam F. Seeley from the position of executive officer of the Procurement and Assignment Service and his transfer to active duty with the Army Medical Department. Since its establishment in October, 1941, Lieut. Col. Sam F. Seeley has held the position as executive officer of this agency, a position which demanded pioneer work, since a similar agency had not previously existed in our governmental system. In this position he made many friends by his invariable cordiality and geniality. He traveled throughout the country speaking to innumerable organizations of physicians, dentists and veterinarians and earned for this agency their respect and cooperation. All who were associated with Lieutenant Colonel Seeley in this work wish him the utmost success in the new assignment to which he has been called—*Jour. A.M.A.*, Sept. 19, 1942.

War and the Doctor: As Canadian Physicians See It

Canada's Armed Forces will need over 800 more medical officers before next March. This need will be met in several ways. In the first place the draft is now bringing in the unmarried doctors 40 years of age and under. Secondly many doctors have signed up directly with the District Medical Officers or by means of the Canadian Medical Association survey last spring. Although many of the latter group are above military age, the Canadian Medical Procurement and Assign-

ment Board is now calling to service a fair number of these volunteers. The third main group, the one from which the bulk of enlistments are expected, is that consisting of medical men 40 years and under who practice in the urban areas. The country doctors in Ontario have enlisted very much out of proportion to their numbers and there are few rural areas which can now spare any more. This is the reason for the present urgent appeal to the younger doctors who practice in cities and towns. They are needed, and needed immediately.

The problem of providing adequate medical care for the civilian population is also becoming greater. The problem must take second place to that of supplying the fighting forces but it is nevertheless very important. All our ability in organizing the available facilities will be called upon before this war is finished and the sooner the machinery can be perfected the better. The following is an outline of the work done to date together with suggestions for future procedure:

A year ago each county society secretary was written to by central office asking for a report on the distribution of doctors in the county and an opinion as to whether or not this distribution was adequate in relation to population. At central office a wall map measuring about 10x20 feet was erected and the location of each qualified practitioner is marked by a colored pin. County maps showing areas served have also been assembled. These maps are constantly kept up-to-date and while they show the distribution of doctors accurately it is difficult centrally to keep track of doctors who are inactive because of age or illness.

Each county society secretary should keep a current record of the county population, the number of active practitioners, and their locations in the county. The county society executive should consider it a duty to meet once monthly for the duration for the purpose of studying the problems of providing adequate care for the people in their area. Some or all of the following methods may be necessary:

1. Instruction of the public.
2. Employment of medical aids.
3. Zoning for emergency calls.
4. Zoning for house calls.
5. Rationing of service.
6. Transfer and subsidizing of doctors.

1. *Regarding instruction of the public* it was thought worth while to try the effect of press releases from central office. Gasoline rationing, the shortage of tires and the decrease in practicing physicians were stressed and the public was requested to consider the doctor's need for rest, and freedom from interruption at meals. A plea was made for the placing of house calls during the morning rather than later in the day. The larger city papers accepted this publicity but the smaller newspapers throughout the province did not respond satisfactorily. The cooperation of the public is most essential and this work could be done more effectively if the county society secretaries would send a few paragraphs at periodic intervals to each newspaper in the county. Stress might well be placed on the value of individual attention to diet and hygiene.

2. *Already the hospitals are planning to train nurses* to do some of the work of interns. Out in practice the same general idea can be applied when the doctor's time is at a premium. A well trained nurse can handle a lot of dressings in both office and home. Many can learn to give anaesthetics for maternity cases and a few can be taught to give intravenous solutions. Cancer patients, diabetics, cases requiring catheterization, etc., will receive less personal attention from the doctor and more care from capable members of the household as the war goes on. There are many ways by which the

doctor can efficiently manage his time so as to be available for the acutely ill and yet not neglect the others.

3. *Zoning for emergency calls* should be instituted throughout the province now. There is no reason why a doctor should go 15 miles and use up good tires and gasoline if a lady who faints lives only a mile from another doctor. The county society executives can tentatively map out the zones and have them discussed at a general meeting. When the zones are made definite a copy should be given to each doctor, to the telephone offices, the fire halls, and the police stations.

4. *Zoning for ordinary day visits* will be a later development. When doctors become fewer it will be impossible to give the patient a free choice of physician. In many areas the patient will be lucky to get any physician at all. He certainly won't be in a position to select Doctor X because he belongs to the same bridge club. Nor will Doctor A be going ten miles past Doctor B's office to see a patient while Doctor B goes ten miles past his office to see another patient. The same zones already in use for emergencies can be applied here. Each doctor will know his own and the other areas and will be able to tell the patient which doctor to call. This system would save a tremendous amount of driving especially in the rural areas.

5. *By the rationing of medical services* is meant the limitation or exclusion of luxury care. Neuroses are less common in war time for the simple reason that more people are working. They have less time to think about themselves and their various organs. There will still be some who demand unnecessary attention and even neurotics should not be neglected. But the question should not be "Does he want me?" but "Does he need me?" Luxury medical care is out for the duration.

6. *The final method for ensuring adequate medical care* is the transfer of doctors from urban to rural areas. A certain amount of this may occur through retired practitioners volunteering to help out during the emergency. Another possibility is the increased utilization of the Red Cross Community Doctor Plan. Under this arrangement there is activity by the Red Cross branch in organizing the citizens to subscribe funds. A salary of \$4,000 is guaranteed by the Red Cross and a doctor unfit for military service is given a contract for the duration. A further possibility is that governmental authority will be granted to the Canadian Medical P. and A. Board to make transfers and allow subsidies in poorer communities. In other words as long as this war lasts there must be a continued and efficient adjustment to circumstances with every person serving to the best of his ability in the place where he will give his greatest contribution.—Ontario Medical Association *Bulletin*, August, 1942.

On Procurement and Assignment: As Seen By Texas State Journal of Medicine

... As has been many times stated by Procurement and Assignment, its responsibility is to see that the armed forces of our country are supplied with doctors 100 per cent, and without any more serious dislocation of civil practice than is necessary. This service must be rendered on strictly an advisory basis. In short, it is up to Procurement and Assignment, through its local, state, and corps area committees, to survey each community in the country, determine the minimum number of physicians necessary to protect the people of any given community, declare that many physicians not available for military service, and conversely, the balance of them as available. This procedure must of necessity be initiated by the county committee. It is a difficult task, and the committee is not to be envied its job. However,

it is a necessary task, and the service must be rendered by somebody. Certainly the state chairman cannot sit at his desk and make the survey and the determination. In order to insure equity in the treatment of the communities throughout the country, both the people and the doctors, it was very wisely determined in the beginning that the medical profession should itself handle the situation and make the decisions. The committees of Procurement and Assignment throughout have been appointed by the federal government, but they are, throughout, at least in Texas, committees selected by county medical societies and the State Medical Association. There can be no better method of insuring the acquiescence and coöperation of the medical profession in this most important governmental function.

The State Committee on Procurement and Assignment has been advised from Washington that both the Army and the Navy are in dire need of physicians from the younger age brackets. The reason for this need is the very rapid organization of a very large Army, larger and more rapidly organized than has heretofore been thought possible. The younger men are needed for field service, a service which cannot be rendered by physicians from the upper age brackets, taking them by and large. We do not recall that any of our armed forces have refused to accept a well qualified physician who is beginning to get gray and to wonder what he has done with his money, but the immediate and emergency need is the doctor full of vim, vinegar and vigor, who is able to take the field and stay there whatever betide. . . .

We are not winning this war. We are not going to win this war if we do not get busy, not just a few of us, but all of us, including the medical profession. There won't be any practice of medicine in the sense that we know it if we lose this war. There probably isn't going to be much left of what we now know of it if we win, but certainly we cannot contemplate losing it. We cannot win it without troops, and still more troops, and we cannot put troops in the field without doctors, and still more doctors. Our responsibility is great. It is up to us to ration our services, turning over to the armed forces what they must have, and giving the people what is left. We must not, until we are told to do so, leave the public without at least a minimum of medical service. No one knows what that is or should be. Procurement and Assignment is doing its best to decide, and the medical profession, particularly organized medicine, should sympathize with and support Procurement and Assignment committees in their efforts to render a difficult and frequently embarrassing service.

Gasoline Rationing

Some comments from *Medical News* of the Providence Medical Association (Vol. III, No. 8):

Gasoline—and how we shall use it—seems to be the subject prominent in the minds of most of the profession just at present. . . .

We as physicians must help out in the program. The people of this country have become so accustomed to having whatever they want that they hate to make any sacrifice whatsoever. They leave this to the boys who have shouldered their guns and gone forth to battle. We too must sacrifice and under no circumstances use our position as doctors as a ruse to acquire more than our just share of those things which others are forced to give up. . . .

A survey a year ago by the Automobile Manufacturers Association—before rationing was dreamed of—gave some indication of the need of the auto by the busy doctor. Nine out of ten doctors used them in their work; the average mileage per year was 12,932. Of the

trips taken by the doctor, 89 per cent were "necessity trips." The average mileage was topped only by that of the salesman who uses his car for traveling. Such statistics provide ample proof of the fact that a car is essential to the doctor's practice. The old horse and buggy days are gone. Those were the days of a community practice, when a doctor was called in consultation at some distance, he used the train. We may likewise be soon following such a routine. When tires are worn out, we may return to many not unpleasant habits of our forefathers.

Special privileges carry corresponding obligations. Let us set a good example in coöperation that we may avoid public criticism. Our profession is respected and we must not allow ourselves to lose this respect. Let us show the country that we too are out for victory and are willing to do our bit to hasten this end.

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PROFESSIONAL MILEAGE RECORD

With this issue of *Medical News* each doctor is being sent a card on which to record his automobile mileage for his professional work in the next three months. This information will be of great value to the individual doctor as evidence of his need for supplemental gasoline rations in future months, especially in view of the fact that the information will be required on the affidavit submitted to the war price and rationing board when seeking replacement. The information will also be of help in listing professional automobile travel for income tax returns.

By recording the start and finish readings of the total mileage gauge each week a doctor will be able to accumulate a total report of his automobile travel. Inasmuch as necessitous home driving has already been determined at 90 miles a month by the Office of Price Administration, the doctor may easily compute his professional driving from his record card as a basis for supplemental ration.

Attention is directed to the fact that the "A" book of basic ration is good for one year. The "B" and "C" ration books for limited occupational and for preferred mileage are dated to expire three months from date of issue.

Rationing is figured on a mileage basis and the mileage per gallon is estimated at 15. However, provision has been made on our record card for the listing of the gas consumption so that the doctor may estimate the approximate mileage of his automobile per gallon of gasoline.

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(COPY)

(Compliments of the Providence Medical Association)

AUTOMOBILE MILEAGE

(Professional mileage record for gas rationing)

Note: In as much as the initial application under the permanent gasoline rationing plan required an estimate of average mileage per month for the next three months for driving in performance of occupational duties, we suggest that doctors chart their weekly mileage on this card. Supplemental rations in the future will undoubtedly be based on proof of driving in previous period.

Name.....M. D.

Home address.....
.....

Gasoline ration book numbers.....
.....

(For recordings the use of the total mileage gauge is suggested)

Month			Weekly	
	Week of	Start	Finish	Total Gas Used

Note: Card measures 3½ by 6 inches.

Doctor—You Have a Job to Do!

Between now and January 1, the armed forces of the United States will need upward of 20,000 members of the medical profession.

That could mean you. Very likely it does mean you. There is that matter of your responsibility to your private practice. Perhaps that has stayed you in delaying to give the armed forces of the United States the benefit of your skill and your experience. Perhaps your patients do feel that they need you, and are not selfish in that sentiment.

However, there is a broader aspect of this situation in these times in which we live.

The very same patients who feel that your leaving them now for the greater field of medical effort might well be the first to wonder about the treatment their sons, their brothers, their fathers are getting, far removed from the security of home and fireside.

The United States Government has guaranteed those men who have gone so gallantly into all the branches of the Service the highest quality of medical attention possible. That guarantee can be kept only by your presence when this medical roll call that is sounding now has been answered in its entirety.

You see now, don't you, why you will be among the 20,000 as soon after this meets your eye, as the settlement of your private affairs will permit?

Actually there are no private affairs in this war. It's public. We didn't make it so. But that's the way it is. —Chicago Medical Society *Bulletin*.

Physicians on the Go as Army Calls for Assistance

Two-thirds of all the physicians under 45 must join the armed forces. Already gaps yawn in our civilian medical defense, partly because many doctors have become officers, partly because little towns have skyrocketed in population. Bremerton, Washington, which once had 30,000 inhabitants, will soon have 40,000, to which another 30,000 in the surrounding area must be added for medical purposes. Nine of the town's 28 physicians have been called to active duty. And so it is with Waynesville, Missouri; Vallejo, California; Wichita, Kansas; Valparaiso, Florida, and scores of other communities.

The few physicians left work around the clock heroically, but hopelessly, see 40 to 50 patients a day, postpone home visits, drive themselves to the verge of collapse, admitting that the quality of service rendered is poor and that it is getting worse.

Paul V. McNutt touched on this crisis before the American Medical Association, and, though he did not say so, left no doubt that we must reform the system of medical practice if we are to make the most of our industrial manpower. Even in normal times some 350,000,000 man-days are lost annually through sickness and

accidents. And now there is an annual increase of 10 per cent.

Mr. McNutt threatened action by the government. It would be far better if industry were permitted and charged to act. Industry can usually afford to pay good salaries to doctors and set up its own hospitals and clinics. If a company is too small to engage in large-scale medical care, it can encourage its employees to participate in prepayment plans based on group-practice—something already done in California and Michigan. When enough physicians are available, local panels can be set up, with fees paid from a prepayment fund—the policy followed by organizations near Binghamton, New York. Where physicians have joined the colors others can be imported to work in a local clinic or hospital, as the Tennessee Coal and Iron Company has demonstrated. Or we may follow England's example and insist that all firms with more than 250 employees establish health services within their own plants and insure for the sick on prepayment basis.

Whatever plan we adopt, the time has come to create a national pool of doctors on which we can draw for both the armed forces and the civilian population—a pool from which physicians would be allocated, with financial guarantees. The cost of such a plan should not be inordinate.

There is evidence enough that workers prefer to pay within their means rather than to accept charity. We simply cannot afford to throw the whole burden of medical care on a few local doctors and imagine that we can win this medical war on the "business as usual" principle.—Woodland Democrat, August 5.

Army Reflects Medical Progress

Twenty-five years is a brief period of time as history goes—but in that time the American people have shown a remarkable growth in their physical stature. The Army is authority for that statement. The average height and weight of the men in our present Army is substantially greater than the average in our World War I forces.

That has been the result of a number of factors, one of the most important of which has been advances made in American medical and health practices. In the years between 1917 and 1942, the medical progress made in this country was literally extraordinary. New and successful cures were found for serious diseases. Advanced methods of caring for mothers and children were developed. Great strides were taken in the science of nutrition. A definite betterment in the physical well-being of the people was the consequence.

It is generally believed that the American Army is physically unsurpassed—as the magnificent performance of our individual soldiers in combat proves. The Army is simply a cross-section of the American people. And the American people enjoy the highest standards of medical care which human knowledge and a free medical profession make possible.—Stockton Record, August 3.

Called to Colors

Physicians and surgeons are leaving home for the armed services in increasing numbers, in response to a heavy recruiting program among medical men under the age of 45.

In some localities, doctors available for "normal" civilian service are already few and far between. Imperial County, with a population of 60,000, will have but 10 doctors—one to 6,000 population—when those scheduled to leave join those already in service, whereas in war time according to an article in the current Journal of the American Medical Association, the civilian popula-

tion should have one doctor for each unit of 1,500 civilians. Yet even where this ratio cannot be maintained, practical Army and civilian medical authorities say bluntly, persons really in need of medical or surgical attention may be cared for adequately if the public will exercise common sense.

The basic rule given may be boiled down to a sentence: doctors are for sick people. Aunt Daphne, who habitually calls in the family physician for several hours a month to discuss her "symptoms," will just have to forego enjoying poor health for the duration. Ladies who trot to doctors' offices to whimper about their "nerves" usually aren't sick; they are, nine times in ten, suffering from nothing that a hard day's work in some useful war activity wouldn't cure. And men who take up doctors' time over complaints purely or largely imaginary are by no means rare either, medical experts indicate.

From now on, every good doctor will have his hands full caring for those who have genuine need of him—on the battle front and on the home front.—Willows Journal.—Oroville Mercury-Register, July 25.

The Doctor in Wartime

A short time ago, an American Medical Association official observed that doctor calls might have to be "rationed" for the duration. The reason behind this is the immense number of doctors being called for service in the military forces. According to army heads, thousands more will be needed in the future.

American medicine is rising to this emergency with its typical spirit. Retired doctors are coming back into harness, and taking over the practices of younger men who have joined the Army and Navy. Other doctors are working harder, and serving an increased number of patients. And during this difficult period the patient himself can help keep medical practices at the high standards to which we are accustomed.

Don't waste your doctor's time. Don't ask him to make a house call when you are perfectly capable of going to his office. Don't make his visits a social occasion, and expect him to sit around and visit for an hour after he gets through treating you. If, through your thoughtlessness, the doctor is forced to dissipate time, someone who urgently needs his attention may have to go without.

American medicine can serve both the armed forces and the civilian population with efficiency if patients will cooperate.—San Francisco Organized Labor, August 8.

MEDICAL EPONYM

Purkinje Fibers

These fibers were described by Professor Johann Evangelista von Purkinje (1787-1869), of Prague, in an article "Mikroskopisch-neurologische Beobachtungen [Microscopic-neurologic Observations]," published in the *Archiv für Anatomie, Physiologie und Wissenschaftliche Medizin* (681:281-295, 1845). A portion of the translation follows:

"On the inner walls of the ventricles of the sheep's heart, I observed, first with the naked eye, a network of gray, flat, gelatinous threads immediately beneath the serous membrane. . . . On microscopic examination, I found these threads to be entirely made up of granules. . . . Inside each granule, there were one or two nuclei without any spherical envelope such as is seen in true ganglion cells. The fibers were formed of cross rows of five or ten of these granules, arranged serially in bundles."—R. W. B., in *New England Journal of Medicine*.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

California's Proposed Basic Science Law

November third is only two weeks away. What will the voters of California have to say on that date about your Basic Science Act, Proposition No. 3?

The answer to that question lies with you. If you will tell the voters what the Basic Science Act is, what it means to the public, why it is necessary for the protection of public health, the act will pass. Conversely, if the voter is uninformed, he will automatically say "no."

The medical profession and its allied organizations are faced with an educational task if Proposition No. 3 is to pass. It is your obligation to see that the voters are informed. It is your duty to scotch the dogmatic arguments which have been advanced in opposition to this act.

Here is something to bear in mind: Of all the organizations in the State which have studied Proposition No. 3, not one has recommended a "no" vote on it. True, some organizations have looked it over and have decided that it is not within the scope of their normal activities or study problems; some of these have passed it by with no recommendation. But not one has come out with a recommendation for a negative vote.

Those organizations which have actually studied the bill as a part of their agenda have unanimously recommended and endorsed it. The Civic League of Improvement Clubs and Associations in San Francisco, the most widespread and influential governmental study group in that city, has recommended a "yes" vote. The same applies to other groups too numerous to mention.

Time is short. Voters are in the dark. It is up to each of you, and your friends and associates, to make sure that the voters know the truth about Proposition No. 3. There is a definite answer to every one of the arguments advanced by cultists; if you know the answers, you can settle any incipient doubts in the minds of people you contact.

If you haven't already learned the complete story to pass on to your friends, the voters, write for more details. Literature is yours for the asking. If you want more than you have already received, ask for it. Your patients and friends will need it to be properly informed before November 3. It is your job to see that they get it.

Let's make these last two weeks count.

Basic Science Initiative: Proposition No. 3

What They're About: Propositions on Ballot. Today: State Proposition No. 3.

The *Call-Bulletin* herewith presents the third in a series of daily articles dealing with the state and local propositions on the November 3 ballot. The discussions are factual and unbiased, and equal emphasis is given arguments pro and con.

PROPOSITION No. 3

This proposition would require that practitioners of the medical, dental, osteopathic or chiropractic professions pass an examination in basic sciences before applying to their respective boards for license to practice.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M.D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

For address of California Public Health League, see adv. page 6.

A special board of examiners would be set up to administer the basic examinations and to issue certificates to those qualifying. Sciences required would be anatomy, physiology, biochemistry, bacteriology and pathology.

Present licenses in the professions involved, and those who treat sickness by prayer in the practice of any recognized religion are specifically exempted from the provisions of the act.

Proponents of the measure point out that its purpose is to insure that those practicing the healing-art have at least an elementary knowledge of the fundamental sciences relating to the human body.

They point out that sixteen states and the District of Columbia now have basic science acts, and that California is the only Pacific Coast state lacking such a law.

Opponents declare that the act would create an unnecessary new board whose functions would overlap and duplicate those of the present medical, dental, osteopathic and chiropractic examining boards. The latter, opponents argue, now require applicants to pass examinations in the basic subjects pertaining to their respective professions. They accredit the proposition to a "minority group who desire to exercise bureaucratic control over existing boards."—San Francisco *Call-Bulletin*, September 30.

Alien Physicians

Shall They Be Licensed? Standards Must Be Maintained

Refugee physicians were and are a sore spot in medical practice. Two years ago we had too many physicians in practice and the addition of refugee physicians to an already overpopulated medical practice gave considerable alarm. This applied as well to American-born physicians who had received their training abroad and who wished to return to their own country to practice their profession.

Properly qualified physicians are always welcome, and by properly qualified are meant medically, sociologically and personally. The big sticking point was the certification of medical qualifications. Many of the refugees were unable to obtain the proper certificates, others had certificates from medical schools and hospitals which had no established standards in this country and conditions in Europe precluded the possibility of establishing such standards. Standardization of American schools was won after a long and unpleasant battle, and Boards of Medical Examiners have finally become quite uniform in their requirements for graduates of American schools.

When this new and unpredictable problem presented itself, many of our Boards made, as requirement for a license to practice, an additional year in an approved American medical school or hospital. The few hardships were far outweighed by the safety from flooding the profession with undesirables.

Well and good, but now the picture has changed. It is considered that for civilian needs there shall be only one physician for every 1500 population. We have already felt what this means and we all know what is in store for those who remain in civilian practice as far as hours of work and increased responsibility are concerned. Will we, then, let down the bars which were so carefully and thoughtfully built up? Undesirables as well as desirables will be granted licenses to practice medicine and we will be giving up a principle which we have promised to protect with our utmost zeal, that no one will be admitted to the practice of medicine who cannot furnish satisfactory proof of having the high qualifications which feature medical practice in the United States.

From this stand we must not retreat. Those refugee and alien physicians who are capable and willing to meet our requirements should have done so by the indicated procedure for the respective states. These we are glad

to welcome, but those who are still hoping to obtain their licenses without fulfilling the requirements are no more welcome in these times of stress than they were two years ago. The civilian population must be protected as well as served and it is our continuing duty to see that whoever is to give civilians medical care must be properly qualified to render that care.—*Northwest Medicine*, August, 1942.

SOME PROPOSED FEDERAL LEGISLATION

The Revenue Act of 1942—Taxation of Accounts Receivable—Income of Charitable Hospitals—Deductions of Medical Expenses.—The House of Representatives has completed action on H. R. 7378, the Revenue Act of 1942, and the Senate Committee on Finance is now holding hearings on the bill.

As passed by the House, the bill increases the normal income tax rate on individuals from 4 per cent to 6 per cent and the surtax will start at 13 per cent instead of 6 per cent for the first \$2,000 surtax net income, with a constant increase in the rate for incomes in the higher brackets. The personal exemption for a single person will be \$500, for a married person, \$1,200. Deductions for dependents will remain as in the existing law at \$400. A new provision authorizes an *additional* deduction for persons in service by exempting from taxation so much of the amount received during the year by an individual in the military or naval forces as salary or compensation in any form from the United States for active service in such forces, as does not exceed \$250 in the case of a single person and \$300 in the case of a married person. The bill proposes no change in the earned income credit.

An important change is proposed in connection with the taxation of accounts receivable on the books of a taxpayer at the time of death. Heretofore such accounts have been includible as income for the year of death, even though the taxpayer may have theretofore been on a cash receipts and disbursements basis. The inequity of this situation as it affected particularly the estates of physicians was pointed out in the J.A.M.A. for January 10, 1942, page 149. By so including the uncollected accounts for tax purposes, along with the income actually received, the taxable income for the year of death is artificially built up, subjecting it to higher tax rates, and in many instances imposing a considerable hardship on the estate of the taxpayer to raise the necessary funds to pay the tax. Under the Revenue Act of 1942, such outstanding accounts will not be includible as income for the year of death of the taxpayer but will be subject to tax as collected, the tax being paid by the person who actually receives the sums collected. Provision is made whereby the estate of taxpayers that have in past years suffered by reason of the unjust operation of the present law may obtain refunds.

The Treasury Department recommended to the House Committee on Ways and Means, at the time the tax bill was being considered, that income derived by corporations now exempt from taxation, such as hospitals operated not for profit, should be subject to income taxes if the income was derived from the operation of a business venture not necessarily incident to their exempt activities. The House Committee on Ways and Means, however, decided to defer action on this proposal and the pending bill makes no changes with respect to the taxation of the income of exempt corporations.

The Treasury Department, too, recommended that taxpayers be authorized to deduct "extraordinary medical expenses that are in excess of a specified percentage of

the family's net income." Ref. FLB—15, p. 4. The pending bill contains no such authorization. . . .

Medical Care for Recipients of Public Assistance under Social Security Act.—H. R. 7411, introduced by Representative Coffee of Washington, July 20, and pending in the House Committee on Ways and Means. A bill to amend the Social Security Act to enable States to provide medical care for recipients of public assistance.

Comment.—This bill provides for federal grants to assist States in providing medical care for the aged, the blind, and dependent children who are recipients of public assistance under the Social Security Act. At the option of the State, needy members of the household of such recipients may also be furnished medical care. For the first fiscal year of its operation, the sum of \$18,000,000 is proposed and for each fiscal year thereafter a sum sufficient to carry out the purposes of the bill. This money will be used in making allotments to the several States which have developed plans that have been approved by the Social Security Board.

A state plan for medical care must provide:

- (1) That it will be in effect in all political subdivisions of the State, and if administered by them, be mandatory upon them;
- (2) For financial participation by the State;
- (3) Either for the establishment or designation of a single state agency to administer the plan, or provide for the establishment or designation of a single state agency to supervise the administration of the plan;
- (4) For granting to any individual, whose claim for medical care is denied, an opportunity for a fair hearing before the state agency;
- (5) For such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Board may exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Board to be necessary for the proper and efficient operation of the plan;
- (6) That the state agency will make such reports, in such form and containing such information, as the Board may from time to time require, and comply with such provisions as the Board may from time to time find necessary to assure the correctness and verification of such reports;
- (7) That the state agency shall, in determining need, take into consideration any other income and resources of an individual claiming medical care; and
- (8) Safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. . . .

Domiciliary Care for Discharged Disabled Veterans.—S. 2727, introduced by Senator Schwartz, Wyoming, August 20, and pending in the Senate Committee on Pensions. A bill to provide domiciliary care for discharged disabled veterans pending adjudication of claim for pension.

Comment.—This bill provides that any person who is discharged from the active military or naval service for disability incurred in such service in line of duty shall be entitled to domiciliary care in a Veterans' Administration facility pending the adjudication of a claim for disability pension, provided such claim for pension is filed by the disabled person with the Veterans' Administration immediately upon discharge from the active military or naval service.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Institutes on Wartime Industrial Health*

Report by the Secretary of the Institutes

California, within the short space of two years, has changed from an agricultural state to an industrial commonwealth. Obviously this alteration has presented new problems to practicing physicians heretofore inexperienced and untutored in the knowledge of the occupational diseases. Appreciation of this fact was voiced at the May, 1942 session of the Western Association of Industrial Physicians and Surgeons. When it was suggested that some form of an educational program be adopted, this body immediately sought and gained the enthusiastic cooperation of the California Medical Association. Subsequently the aid of the California State Department of Public Health was obtained. Arrangement of the program, as well as the meeting places, was left to the Postgraduate Committee of the Western Association of Industrial Physicians and Surgeons.

An entirely new departure from the usual postgraduate program was undertaken. Instead of holding these Institutes at the traditional meeting places of the various county societies, they were taken to the very back yard of the industrial physician—out into the outlying industrial centers. It was felt that by doing this many physicians would be able to attend who otherwise would feel that they could not take the time off to travel any distance.

In retrospect, the meetings were considered to be highly successful. Approximately a little over a thousand physicians were in attendance, as well as a goodly number of industrial nurses, plant managers, personnel directors, etc. The highlights of the meetings were the papers of the guest speakers, Dr. Carey McCord, of Detroit, and J. J. Bloomfield, of the United States Public Health Service, from Bethesda, Maryland; the demonstration of equipment, devices to detect the presence of noxious substances, and the Question Box conducted at the end of each day's session. It is believed that the physicians were especially interested in the demonstration of the various types of apparatus used by the hygienist at the plants. When the second series of meetings is held (which is planned for the latter part of this year), greater emphasis will undoubtedly be placed upon hygienic measures for the prevention of occupational diseases, as well as upon the value of the Question Box.

Credit for the success of these meetings must be given to Dr. George H. Kress, Secretary of the California State Medical Society, who gave unstintingly of his time and interest, as well as placing at the Committee's disposal the services of the C.M.A. Postgraduate Committee; Dr. Bertram P. Brown, Director of Public Health of the State of California, who, through his department, sponsored the financial part of the program and placed at the Institutes' disposal certain of his doctors and office force; and, especially to Dr. William P. Shepherd, who, as Chairman of the Postgraduate Committee of the Western Association of Industrial Physicians and Surgeons, so ably directed the entire program.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

* Report submitted by R. T. Johnstone, M.D., Secretary, Western Association of Industrial Physicians and Surgeons, 423 Towne Avenue, Los Angeles.

Abstracts of addresses appear in this issue of CALIFORNIA AND WESTERN MEDICINE. See index.

Health Officers' Department—League of California Cities

PROGRAM: LOS ANGELES, CALIFORNIA, SEPT. 21-24, 1942

Monday, September 21

8:00 a.m. to 12:15 p.m.—See General Sessions Program.
2:15 p.m. Department Session—Presiding Officer, Warren F. Fox, M.D., Health Officer of Riverside County.

1. Presidential Address—John D. Fuller, M.D., Health Officer of Santa Cruz County.

2. Report of the Secretary—Bertram P. Brown, M.D., Director of Public Health, State of California, San Francisco.

3. The Procurement and Assignment Services and Public Health—Clarence G. Toland, M.D., Los Angeles County Chairman, Procurement and Assignment Service.

4. Report of Legislative Committee.

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Tuesday, September 22

9:00 a.m. Department Session.—Presiding Officer, F. E. Gallison, M.D., Health Officer, Ventura County.

Wartime problems:

1. The Emergency Medical Services—Fred Foard, M.D., Medical Director, Office of Civilian Defense, Ninth Region, San Francisco.

2. Supervision of Public Water Supplies in Wartime—E. A. Reinke, Senior Sanitary Engineer, Civilian Defense, Bureau of Sanitary Engineering, Berkeley, California.

3. Public Health Problems in Wartime—Edward Lee Russell, M.D., Santa Ana, Health Officer of Orange County.

4. The Housing Shortage and the Public Health—Catherine Bauer, Mills College, Oakland.

5. State Subsidies for Tuberculosis Hospitalization—Edward G. Kupka, M.D., Chief, Bureau of Tuberculosis, State Department of Public Health, Los Angeles.

1:30 p.m. Trip to Planetarium—Buses leave 1:30 p.m. from Grand Avenue entrance, Biltmore Hotel.

5:00 p.m. Barbecue—Crystal Springs Picnic Grounds, Griffith Park.

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Wednesday, September 23

9:00 a.m. Department Session—Presiding Officer, Sam Greene, Manager, California Dairy Council, San Francisco.

General Subject: Joint Conference on Problems Related to the Production, Processing and Distribution of Milk Products in Wartime.

1. Tuberculin Testing Program—C. U. Duckworth, D.V.M., California State Department of Agriculture, Sacramento.

2. Problems of the Industry—Darrell Lewis, Arden Farms Company, Los Angeles; Roger Jessup, Roger Jessup Certified Farms, Los Angeles.

3. Inspection Standards—Representative of the dairy inspectors group.

4. Milk for All of California—William J. Cecil, Director, Department of Agriculture, Sacramento.

5. The Health Officer Sees the Problem—Speaker to be announced.

2:15 p.m. Department Session—Presiding Officer, Harrison Eilers, M.D., County Health Officer, San Luis Obispo.

1. Panel Discussion—Nutrition and the War—A. J. Lorenz, Leader, Southern California Nutrition Committee.

2. Plans for Future Development of the Maternal and Child Hygiene Program in California—Jessie Bierman, M.D., Director of Maternal and Child Hygiene, California State Department of Public Health, San Francisco.

3. The Kenny Method for Treatment of Infantile Paralysis—Martin Mills, M.D., Chief, Crippled Children Services, Department of Public Health, San Francisco.

4. The "Penny Milk" Program—Dr. Samuel E. Wood, Supervisor of the Agricultural Marketing Administration, United States Department of Agriculture, San Francisco.

7:00 p.m. Annual Banquet—Health Officers Department—John D. Fuller, M.D., County Health Officer, Santa Cruz, presiding.

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Thursday, September 24

9:00 a.m. Department Session—Presiding Officer, Walter W. Fenton, M.D., County Health Officer, San Bernardino County.

1. Jaundice—Lt. Col. E. Richmond Ware, M.C., United States Army. Discussants—Hubert O. Swartout, M.D., Director, Bureau of Preventable Diseases, Los Angeles County Health Department. Saul Ruby, M.D., Assistant Health Officer, San Diego County.

2. Tropical Diseases and the Present World Conflict—Dr. John F. Kessell, Professor of Bacteriology, University of Southern California, School of Medicine, Los Angeles. Discussant—Norman B. Nelson, M.D., Epidemiologist, City of Los Angeles Health Department.

To Your Health

The annual meeting of the American Medical Association is for most doctors in North America the greatest postgraduate educational opportunity of the year. The lecture sessions in every branch and specialty of medicine present papers which represent the newest discoveries and investigations. A new section was added this year on general practice which is a healthy sign of the times, when laymen ask me nearly every day why they can't get a good family doctor, to whom they can turn over all their medical problems.

The exhibits of manufacturers of drugs, instruments, foods, baby foods, beds, publishers of medical books (there are at least twelve large firms of this character in North America) provide sound education and inspire the doctor to renovate his equipment and keep up with the times.

But the third educational feature of the session, the scientific exhibit, has grown during the last few years until it is really first in educational value.

These exhibits, entirely noncommercial in character, are set up by private doctors to show the work they have been doing in their home town hospitals, clinics or laboratory. By actual demonstrations or photographs, in many cases beautiful and elaborate drawings, and small motion picture exhibits, the new ideas are shown in a succession of booths like a glorified county fair, on the basis that one look at an actual demonstration is worth more than 1,000 words read from any manuscript.

A doctor hears of some treatment given in a far away city; he would like to go to see it for himself. But he hears of five or six of these during the year; and when he gets to the American Medical Association meeting he finds that they all have been brought together under one roof. The demonstrators are physicians in private practice who have developed the method, and have pledged themselves to stay in their booth at the exhibition hall every hour it is open and explain all the details to doctors.

Most of these lectures and exhibits are too technical to attempt to recount for a lay audience.—Logan Clendenin, M. D., in *San Francisco Call-Bulletin*, September 19.

War Declared on Factory Accidents

Doctors, nurses, safety engineers and industrial representatives met yesterday at the Inglewood Country Club to have a go at cracking production's biggest bottleneck—sickness and injury of workers.

The meeting was one of a series sponsored throughout the State by the California department of public health in cooperation with the California Medical Association and the Western Association of Industrial Physicians.

J. J. Bloomfield, safety engineer of the United States public health service, told the representatives of industry that they must go beyond efforts to insure a safe and healthful working environment for their employees if the nation's production is to be notched up to a war winning pitch.

"More than nine-tenths of the 400,000 working days lost last year were due to nonoccupational illness and injury," he declared.

"Crowding, poor housing, lack of sufficient medical facilities, schools, recreation and other welfare services all combine seriously to threaten health and to disrupt normal family life.

"Add to these the mental strain caused by war worries and we have a situation, under which thousands of war workers are now living, which is certainly not conducive to good morale and all-out production.

"Industrial medicine can no longer confine itself to emergency treatment and the diagnosis of occupational diseases. True, there is a bigger job to be done in the plant itself, that is a job of prevention.

"But even this cannot be accomplished without a prompt and responsible recognition of the influence of living conditions upon absenteeism and industrial disability.

"In dealing with the worker, we must adopt a concept of the total man, deal with his health 24 hours a

day, if we are to keep him on the job and enable him to contribute to the common cause."

Bloomfield sounded a note of warning to war plant operators that they are passing by too much manpower through physical restrictions for employment that are too rigid. He said that the war manpower commission is considering advice to the war plants that they relax their requirements somewhat and find places at their work benches for persons somewhat physically handicapped but able to perform certain work.

He warned them also that with the entrance of more older men and under draft age youngsters and women into the war plants, greater effort would have to be made in the proper adjustment of working hours to control fatigue and prevent overwork.

Other Institutes on wartime industrial health, with Dr. Robert T. Legge, past president of the Western Association of Industrial Physicians and Surgeons, serving as chairman, will be held at the Tuesday Afternoon Club, 400 North Central Ave., Glendale, today, and at the Women's Club of Huntington Park, 6828 Rugby Ave., Huntington Park, tomorrow afternoon.—Los Angeles *Daily News*, August 27.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Facts Relating to Present Need for Nurses

Questions invariably asked when the present need for nurses is under discussion include:

How many nurses are there in the country? How many are eligible for military service? How many student nurses are enrolled in nursing schools?

Answers may be found in recent issues of the American Journal of Nursing. In summary they are:

Number of Registered Nurses in the United States According to the National Nursing Inventory

1941	
Total number.....	289,286
Number actively engaged in nursing.....	173,055
Number inactive in nursing but available for full-time work	25,252
Number active and inactive in nursing, eligible for military service.....	75,000

Distribution of Nurses Actively Engaged in Nursing

Total number.....	173,055
Institutional	81,708
Public Health nursing.....	17,776
Industrial	5,512
Private duty.....	46,793
Other	9,940
Unknown	11,336

Number of Nurses Graduated from Nursing Schools

1941	25,875
1940	23,640

Number of Students Enrolled in Nursing Schools

1942 (estimated)	91,000
1941	87,588
1940	85,000
1939	82,000

Admissions to Schools of Nursing During the School Year

1942-43:	
Total number needed.....	55,000
Admissions, summer, 1942.....	3,800
Expected admissions, Fall, 1942.....	36,044
Additional number needed in Fall '42 and Spring '43	15,156

From *Professional Nursing*, Vol. 14, No. 4.

A round man cannot be expected to fit a square hole right away. He must have time to modify his shape.

—Mark Twain, *More Tramps Abroad*. Ch. 71.

COMMITTEE ON SCIENTIFIC WORK

Annual Session, 1943

Plans are proceeding for the 1943 session of the California Medical Association to be held—unless unforeseen complications arise—during the first week of May, 1943, at Hotel Del Monte.

Members of the California Medical Association who are in position to submit papers for the general or section programs should communicate promptly with the Secretary of the proper Scientific Section (addresses of Section Officers are printed in each issue of CALIFORNIA AND WESTERN MEDICINE, on adv. page 6).

For the information of members, a copy of the text of one of the certificates of award, granted at this year's annual session, is presented with this notice.

Prizes for Scientific Exhibits.—Scientific Exhibits by members of the California Medical Association, or by California institutions or organizations will be allocated to three classes: 1. Medical; 2. Surgical; 3. Public Health.

If, in the opinion of the Committee on Awards, exhibits of sufficient merit are displayed, prize awards will be given in each class, as follows:

First prize—\$50.00 and framed certificate;

Second prize—\$25.00 and framed certificate;

Third prize—Honorable Mention.



Awards This

Certificate of Merit

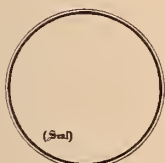
First Prize

in
Assembly of Scientific Exhibits
Section on Medicine

to
Samuel Ayres, Jr., M.D.
Nelson Paul Anderson, M.D.
For Exhibit:

Dermatoses
Common Under War Conditions

Seventy-First Annual Session
Del Monte
May 5-6, 1942



President

Secretary

COMMITTEE ON MEDICAL ECONOMICS

Re: Nonprofit Medical Service

The *New York State Journal of Medicine*, Vol. 42, No. 13, July 1, 1942, printed the following item, not without interest to physicians in California.

PUT UP, OR SHUT UP!

"The introduction of the 'Hampton Bill' in the session of the legislature just closed signalizes the end of the period of grace in which," says the *Westchester Medical Bulletin*, "the medical profession has been permitted to carry on a dignified debate as to whether it should or should not give unreserved support to medical expense insurance under medical auspices."

Due to the common-sense decision of the House of Delegates at its 1942 Annual Meeting, such unreserved support for all three of the plans operating in the State of New York was obtained. The reference committee of the House of Delegates reported "that the situation is serious and the emergency genuine." It specifically recommended:

"1. That all county medical societies be contacted and assisted and immediately urged to cooperate with approved plans.

"2. That the State Medical Society through its Subcommittee give all aid at its command to help these county medical societies succeed with this work.

"3. That the principles of nonprofit medical insurance be re-emphasized as adopted in the 1941 report.

"4. That intense energy be used to obtain a larger number of subscribers among the low-income groups.

"5. That hospitalization and medical care plans remain independent of each other. . . ."

Let us get down to a little plain speaking on this subject. The directions of the House of Delegates as set forth above, are direct and simple. Boiled down, they say: *Get busy. This means you!*

You may or may not have attended the meetings of the House. If you did, you heard the report and have no excuse for not getting busy, if you have not already done so. If you didn't attend, but can read, you saw in this JOURNAL, in the issue of June 1, an editorial "Now for Action," which was based on the cited directions of the House of Delegates and which urged you to get behind your regional nonprofit medical expense indemnity plan and push.

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There is only one way in which the membership of the Society can be told the facts of life at reasonable expense, and that is through the printed word—in this case, your JOURNAL. If you don't read it, the entire profession of the state may be placed in jeopardy; if you do read it, but do nothing to comply with the specific instructions of your own legislative body, then, no matter what happens, the medical profession can blame nobody or anything but its own indifference.

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Put up, or shut up. "The 'Hampton Bill' was introduced at the direct request of the Insurance Department and would almost certainly have been adopted by the legislature if the Insurance Department had not later requested that it be held over for one year." Of that year, seven months have now elapsed. The sands are running out. What will you do about it?

If you are concerned with this problem, the first logical step is to become a professional member of your regional plan. . . .

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When you have done so, your next opportunity to make your influence felt is to bring the plan to the attention of your patients with the recommendation "that they request their employers, trade associations, and other groups with which they are affiliated to avail themselves of this modern type of protection against 'medical economic catastrophes.'" It's *your* plan; it's *your* responsibility; you have to make it work. If you don't, and the time is growing short, you may expect the Hampton Bill or a similar one to be passed by the legislature next year whereby the services of physicians will become merely incidental to hospitalization. This is plain speaking: Nobody will do it for you. Do it yourself, and do it now. Put up, or shut up!"

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (7)

Alameda County (5)

Robert R. Hampton, *Oakland*
William D. McCarthy, *Oakland*
Hannah Peters, *Oakland*
Thomas Reich, *Oakland*
Janet Sampson, *Oakland*

Monterey County (1)

Robert H. Schock, *Soledad*

Santa Barbara County (1)

Clifford F. Jones, *Santa Barbara*

Retired Members (2)

Joseph A. Champion, *San Bernardino County*
Will R. Manning, *Ventura County*

In Memoriam

Anderson, Oscar. Died at Long Beach, September 6, 1942, age 68. Graduate of Dunham Medical College, Chicago, 1902. Licensed in California in 1909. Doctor Anderson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Bowers, William Sidney. Died at Los Angeles, September 4, 1942, age 47. Graduate of College of Physicians and Surgeons, Los Angeles, 1919. Licensed in California in 1919. Doctor Bowers was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.



Finch, William Clinton. Died at Los Angeles, August 10, 1942, age 69. Graduate of University of Louisville School of Medicine, Louisville, 1897. Licensed in California in 1898. Doctor Finch was a retired member of the Los Angeles County Medical Association and the California Medical Association.



Hoffman, Rubin Ora. Died at San Diego, August 16, 1942, age 74. Graduate of Eclectic Medical College, Cincinnati, 1891. Licensed in California in 1908. Doctor Hoffman was a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.



Wood, William Almon. Died at Oakland, July 21, 1942, age 66. Graduate of University of Southern California School of Medicine, Los Angeles, 1906. Licensed in California in 1909. Doctor Wood was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



OBITUARIES

Moses Scholtz

1875—1942

"No man can be great in his own profession who

has not a vigorous intellectual life outside of it, beyond it and above it."

These are the words of Andrew Preston Peabody. They are wise words and they find eloquent example in the distinguished career of Dr. Moses Scholtz. To the profession in general, Dr. Scholtz was a revered colleague, a great dermatologist, a gifted clinician. That, however, is but part of the picture. He was also a man of broad sympathies and understanding heart. Those who were fortunate enough to have his friendship were ever enriched and inspired by his keen and cultivated mind, by his profound interest in general culture. Through the varied activities in which these qualities found expression, Dr. Scholtz added much of richness and integrity to the life of the city in which he held an enviable rôle of leadership.

A fair knowledge of French and German is generally considered indispensable to those who desire full command of their respective departments of science. To Dr. Scholtz, that was not enough. He became a master of both these languages. He penetrated their literatures and took delight in writing poetry in French.

His finely disciplined and logical mind was supplemented by his deep responsiveness to beauty, by his love of nature (especially at his ranch in Arcadia), by his sensitive enjoyment of great music, by his fine aliveness to verse and all other departments of artistic expression.

His point of view on social questions, political economy or any current event, was invariably voiced with clarity, elegance and touches of humor.

With a personality so well integrated, with a mind so harmonious and finely balanced, he was able easily to combine his serious productive pursuits with the stimulating relaxation of a game of chess or bridge. But even in the sphere of diversion, his mental vigor was never content with mere passive ease. As a champion at chess, as a scientific bridge player, he showed consistently the same thoroughness and determination exhibited in other facets of his life.

Moses Scholtz—here was a man completely, warmly and productively alive. We who knew and loved him find comfort in the rich and vivid memory of one who so finely embodied the nobility and dignity which human life can attain.

GABRIEL SEGALL, M. D.



Edward Charles Fabre-Rajotte

1875—1942

Since January 2, 1917, Dr. Edward Charles Fabre-Rajotte had been a valued member of the San Francisco County Medical Society. On September 14, 1942, he passed away, leaving a host of friends and associates who will feel his departure as a great loss, not only to themselves, but to the medical profession as well.

Chief surgeon of the Eye, Ear, Nose and Throat Department at San Francisco's French Hospital since 1915, Doctor Fabre-Rajotte served as consulting oculist to the Metropolitan Life Insurance Company, and carried on an extensive practice at his office at 450 Sutter Street.

Doctor Fabre-Rajotte was born at Aylmer, Quebec, Canada, in 1875. He was educated at St. Louis College, and McGill University at Montreal, where he received his degree in the year 1899, becoming a member of the Quebec College of Physicians and Surgeons also in that year. In 1911-12, he served on the faculty of the University of Paris, France, and was Ex-Associate Chief Ophthalmologist there from 1911 to 1913.

Doctor Fabre-Rajotte served with the U. S. Volunteer Medical Service Corps in 1918, and was awarded the Chevalier of the Legion of Honor of France in 1935. Author of numerous medical reports, he was well known

† For roster of officers of component county medical societies, see page 4 in front advertising section.

both here and abroad. He was a member of the California Medical Association, the American Medical Association, the Pacific Coast Oto-Ophthalmological Society, as well as the County Medical Society.

Always scrupulously attired, the gallant red ribbon upon his breast, Edward Fabre-Rajotte will long be remembered as a charming and colorful gentleman of the old school, whose presence among us was a constant reminder of a day that will never come again.

HAROLD M. F. BEHNEMAN, M. D.



Donald S. Gidley

1905—1942

Doctor Donald S. Gidley died at Fort Lewis, Washington, July 5, 1942, at the age of 37. He was a graduate of the University of Oregon Medical School, Class of 1930, and was licensed in California in 1931. Dr. Gidley enlisted in the Medical Reserve Corps as a First Lieutenant in October, 1939, was promoted to a captaincy in October, 1940.

On March 1, 1941, he entered active service in the Medical Corps and received his majority on June 15, 1942. At the time of his death, he was the Regimental Surgeon at Fort Lewis. Major Gidley was in active practice in Ontario and a member of the San Bernardino County Medical Association and the California Medical Association, and was also a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM...Asst. Chairman on Publicity

President Lindemulder's Suggestions and Projects for 1942-1943

Never before has the Auxiliary faced such a challenge as it faces today, for our husbands are being called into the Service, either into the armed forces or into civilian duty in the defense areas. When this happens, it is our first tendency to drop everything, and take less and less interest in things that formerly occupied our time. I want you to realize that this is the time you are needed, as *auxiliary members*, more than ever. We have an opportunity for service that no other group can offer. We are doctors' wives, and as such we should be so strong, so united, that no smallest opportunity for service should pass us by. The war has opened new fields of service for us and we should accept the importance of this work. Our husbands have their way of serving our Country by attempting to maintain its present high standard of health. We, also, can serve our Country, through the Auxiliary, by the furtherance of Health Education which is one of our main objectives this year. Read the following carefully, and see if among the suggestions and objects there are not many things that are vitally necessary to your community, and to our Country.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Health Education.—Let every Auxiliary be represented on the program committee of all lay organizations. Suggest that health talks be given by accredited physicians.

Legislation.—Follow the suggestions sent to you by the State Legislation Chairman and the Public Health League. Campaign as hard as possible so that the Basic Science Law (Proposition 3), on the November ballot, will be assured.

The Woman's Auxiliaries to the California Medical Association have been requested to assume their responsibility of bringing to the attention of the women of California, through an Educational Program, the merits of the Basic Science Act. The Presidents of the County Auxiliaries will be responsible for their individual Counties. Women of Northern California are being organized under the leadership of Miss Ethel O'Brien, Field Representative of Public Health League of California. Miss O'Brien will talk to members of the State Board at their Fall meeting which has been scheduled by the State President, Mrs. F. G. Lindemulder, for September 11, at Rio del Mar Country Club, Aptos, California.

Annual Physical Examinations.—Make our motto, "See your doctor once a year." Now that so many of our doctors are being taken away to serve our Country, it is more than ever necessary to *keep* physically fit. By annual examinations, small illnesses can be prevented from becoming big ones.

Nutrition.—See that each Auxiliary is properly educated on how to feed the family. Pass this knowledge along to lay organizations. Improper diets cause many preventable illnesses.

Hygeia.—It is important to see that this health magazine is placed in all public schools, camps, libraries and homes. It is the only authentic health publication printed for the lay reader, and in itself will do much to help keep our Country fit. Let every member subscribe, and if she has no need for the magazine, see that her subscription goes to some place where it is needed. Remember, we are not magazine salesmen when we advocate the sale of *Hygeia*, but we are health teachers and supporters.

Medical Defense.—The Medical Defense set-up throughout the United States, functions best when it is carried out by local doctors. The Woman's Auxiliary must be prepared to seek and accept leadership in Medical Defense programs rather than work with other organizations and thus dissipate our force as a medical group. The Auxiliary should be the channel through which health education must flow.

Medical Benevolence Fund.—Let us do all we can to support this worthy project that the California Medical Association has started. May every Auxiliary contribute something this year so that we, too, may know that we have helped to the best of our ability.

Friendly Relations.—Because there is a war, do not forget the friendly social contacts. Remember the wife whose husband has gone to war. Keep up morale by being more friendly than ever with other doctors' wives. We have much in common, now more than ever before.

There are many more activities than our Auxiliaries are already maintaining, blood banks, Red Cross, Nurses' Aid, ambulance corps; these are only a few of them. But above all, remember we, as doctors' wives, are going to help hold the home front. We will continue, strong, helping our husbands in every way possible, doing all we can to aid our Country. We will keep a firm and united front, that we may be worthy of the tasks before us.

News Items

Alameda County has continued, throughout the summer

months, the canteen work at the U.S.O. House in Oakland, and members of the group have served the third Tuesday of each month, from 11 a.m. until 10 p.m. Approximately 600 service boys have been entertained there on these days. Mrs. John Saam has acted as chairman with Mrs. A. A. Alexander, Mrs. Robert A. Glenn, and Mrs. William Henry Sargent as hostesses.

* * *

Fresno County held its last meeting of the year in May at the home of the President, Mrs. J. R. Walker, where tradition of last year's gathering was made of having a box supper for the benefit of the Benevolent Fund.

Each member came costumed as her "suppressed desire," and was expected to rid herself of any inhibitions. It seemed apparent that the doctors' wives secretly yearn for public life, as there were ballet dancers, artists, movie stars and even Mother Dionne. Since this party was as private as it was successful for the thirty members present, it was felt that only this much can be divulged.

* * *

The last meeting of the year for the Santa Barbara Auxiliary was held at the El Mirasol Hotel. The group met for luncheon and to wind up the year's business. Thirty-seven members were present, including associate members, most of whom were wives of the officers of Hoff Army Hospital. Santa Barbara is proud that two of its members are on the State Board for the coming year: Mrs. Richard McGovney, as State Treasurer, and Mrs. C. W. Henderson, as State Historian.

Before adjourning, Mrs. John Van Paing called attention to the need of a lounging room equipment at Camp Cook. She urged, therefore, the interest of members in securing radios, victrolas, lamps, sofas, card tables, magazine racks, etc., for the soldiers, and suggested that summer activities might follow this line of endeavor.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939.....	1,220
March, 1940.....	9,322
December, 1940.....	20,993
June, 1941.....	27,632
December, 1941.....	32,562
July, 1942.....	34,520
August, 1942.....	37,081

California Physicians' Service has successfully completed a one-year experiment with low income farm families. This was done on a small scale in three areas of the State, centering around Butte, Sonoma and Monterey Counties. After analyzing the data collected, it was felt that with indicated modification of rates and benefits this program could now be safely extended to the rest of the State. During the months of September, October and November, low income farmers in California will start to enroll and may call upon professional members for services under this plan shortly thereafter.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of non-profit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

For this reason, it is well for each physician to have some information about this plan.

It was developed in conjunction with the Farm Security Administration, which is operating medical plans in practically every State, involving some 400,000 persons. It is the largest medical-care plan in the United States.

The objectives of the F.S.A. are to protect the health of its borrowers and at the same time find a method whereby their physicians will be assured of an adequate fee for their services, and private hospital bills will be paid.

In this state such a plan will redirect a family—whose only resource in the past may have been tax-supported county hospitals or unpaid doctor and hospital bills—back to the private practitioner and private hospital. It brings new money to rural communities.

The majority of the families that will be enrolled are borrowers of the F.S.A. They are borrowers because they have lost local bank credit. Other families who are not borrowers are eligible provided their incomes do not exceed \$2,000 a year. The names of these families are available to local County Medical Societies, and if any of them do not appear to be the kind of family which should be included, we can refuse to take them if a re-investigation of their financial status substantiates our claim.

The Farm Security Administration staff will do all of the organizing and selling of groups. This relieves C.P.S. of considerable expense. All medical administration is, of course, handled by C.P.S. In effect, with this arrangement the government stays on its side of the fence, and the medical profession is in its position of control over professional matters. Such a pattern is desirable, in the face of future socialization of medical and hospital care.

The rates run from \$20.00 a year for a single person to \$60.00 a year for a family of three or more. The contract runs for one year, at which time readjustments can be made.

In general, for this rate families are allowed medical and surgical care for all acute illnesses. Care for chronic illnesses is limited to three weeks. They may have 10 days of hospitalization and \$25.00 toward hospital costs for a delivery. The patient must pay \$1.50 for the first call made to the home in each separate illness. Doctors' referrals and bills will be handled in the same way as regular C.P.S. business is handled, so there are no new forms or paper work to bother with.

Physicians may be getting inquiries from local farm families wishing to join, or leaders of farm groups may wish to discuss the plan with them. The entire movement has the endorsement of the House of Delegates of the California Medical Association, so they may be assured that proper clearance in the interest of the medical profession has been obtained.

These are days when a great many things have been shouldered by the medical profession. A great responsibility has been delegated to us by the War Manpower Commission through the Procurement and Assignment Service. In addition to the task of supplying the armed forces with necessary medical personnel, an important part of this responsibility is to provide adequate medical care to the civilian population.

This is a worthwhile medical plan for our food-producing farmers, in line with this responsibility.

The Counties included in the plan are as follows:

Butte, Colusa, Fresno, Glenn, Imperial, Kern, Kings, Lake, Madera, Marin, Mendocino, Merced, Monterey, Placer, San Benito, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Siskiyou, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Yolo, and Yuba.

MILITARY CLIPPINGS

Military Clippings—Some news items of a military nature from the daily press follow:

Draft Standards For Doctors Set

Washington, Sept. 5.—(AP.)—Standards by which public health physicians should be considered essential in their present work and "non-available for military duty" were announced today by Manpower Chairman Paul V. McNutt.

A physician should be excused from military service, the announcement said, if he comes within one of two categories:

1—A full-time medical officer in charge of a health service of a governmental unit or administrative district, such as State, district, county or city.

2—A full-time head or chief of an administrative unit within a health department.

Physicians in public health positions other than those specified, who are under 37 years of age, the announcement said, "should expect to be released for military service, except under unusual circumstances, and their places should be taken by older persons."—*Oakland Tribune*, September 6.

* * *

Doctors in Service

But Their Offices Are Kept Intact—Policy of One San Francisco Office Building

The management of the 450 Sutter Building has solved one of the biggest problems that doctors and dentists face when they are about to go into the armed services—what to do with their office equipment?

The 450 Sutter Building is allowing doctors and dentists to leave their equipment intact in their offices, and their names remain on the directory and on the doors to their offices.

Says Procter Flanagan, manager of the building:

"We're just trying to do our bit. We let them keep their equipment here and, of course, we charge them no rent while they're gone. We've got about 25 offices like that in the building now.

"At least six of our tenants will have been in the service two years in November and we've kept their equipment for them. We dust the offices about once a month and see to it that no moths get in. When someone comes in looking for one of these tenants, we direct them to whoever is handling their practice.

"If someone wants to rent one of the offices, we try to sell them on some other vacancy. Should we need the space, we have permission of the doctor to move his equipment, for when he goes into the service he gives us a letter saying he has been called in, naming some one with power of attorney for him and absolving us of responsibility for the equipment.

"But you can bet we take good care of the equipment. We want it in good shape for these people when they come back."—*San Francisco News*, September 10.

* * *

Industrial Doctors' Status Maintained

Industrial physicians, full and part time, will be retained in their present positions.

This was the order to State chairman of the War Manpower Commission today as Paul V. McNutt of the WMC, pointed out the threatened serious lack of medical direction in industry through releases of these physicians to the armed forces.

"A serious situation is developing in some States because physicians under 45 years of age who are essential in their present positions as key men in industrial practice are being declared available by State chairmen, or are being approached directly by recruiting boards with instructions to apply for a commission in the Army Medical Corps.

"The selective service system and surgeons general of the Army and Navy are cooperating with us to keep at their posts the physicians declared to be essential by our State committee."

A physician employed in industry is deemed to be essential when the following conditions exist:

(1) The physician is employed by an industry which is manufacturing war materials exclusively or under priority ratings.

(2) The physician gives his full time to the industry or 40 or more hours weekly, has been so employed for at least two years or is especially trained for that purpose and is carrying on an acceptable health maintenance program.

(3) The physician is performing the functions of a medical director or department head or of a specialist or is the only physician employed.

(4) Assistant physicians who perform routine functions under direction, and reemployed on a full-time basis, are deemed essential until they can be replaced within a reasonable time (3 to 6 months).

(5) The physician serves part-time two or more industries engaged exclusively in the manufacture of war materials or under priority ratings, providing his total part-time service is the equivalent of 40 or more hours weekly. The physician who serves on call is not deemed to be essential.

(6) The physician serves a State industrial hygiene bureau on a full-time basis.—*Riverside Press*, September 10.

* * *

Draft Deferment of All Medical Students Asked

Washington, Aug. 29.—(INS.)—Senator Joseph C. Rosier, Democrat, West Virginia, today called upon the selective service system to give serious consideration to permanent deferment from the draft of all medical students, if the health of the nation is to be properly guarded.

"Small communities everywhere are being stripped of their physicians and surgeons," Rosier said. "The large cities are losing most of their younger and middle-aged practitioners."

Rosier, an educator for fifty-one years, has been on leave of absence as president of Fairmont College at Fairmont, W. Va., while serving in the Senate. He also is a member of the committee on education and labor.

"If the war is long," he said, "and we draft the men of 18 and upwards, we will have no new 'crop' of medical men entering pre-medical courses after this September except those few who begin at ages under 18.

"Those entering the pre-medical courses at the best, or class A schools will not complete their training before 1949 if they follow the usual seven year course."

Rosier then explained that those in the six classes to be graduated between now and 1949 will be young men with little experience.

He said: "With the drain which the army and navy will make upon even this supply there is certain to be a dangerous shortage of doctors."—*Fresno Bee*, August 30.

* * *

Base Hospital Staffs Sought for Southern California Doctors to Man Units for Care of Civilians to Be Named at Once

Medical directors and staffs to man base casualty hospitals for civilians injured in the course of sporadic or sustained attack on Southern California will be chosen from 14 selected Southern California hospitals and medical schools, it was announced by Major Charles F. Sebastian, medical officer for the Southern Sector Office of Civilian Defense, yesterday.

Hospital and medical school heads have been asked to nominate 15 "unit directors" who will be approved by Major Sebastian and by Lieut. Col. Fred T. Ford, 9th Regional medical officer for the Office of Civilian Defense.

To Name Staffs

Unit heads will then nominate their staff members who will be similarly approved.

Unit heads of casualty base hospitals, solely for civilians removed from a combat area for convalescent treatment from casualty stations, will be commissioned lieutenant colonels in the United States Public Health Service and placed on the "inactive" list until the event of an attack automatically places them on duty.

Base hospital staffs will include specialists in internal medicine, general surgeons, orthopedic surgeons, a dental surgeon, pathologist and radiologist, Major Sebastian said. Each unit head, he said, has the privilege of nominating 14 other men to comprise his staff.

Institutions Chosen

Institutions from which personnel will be selected are located in Santa Barbara, Ventura, Los Angeles, San Diego and San Bernardino counties.

Men older than 45 are being sought for the base hospital set-up and the only exceptions to this rule will be those who are not accepted by the Army physically but who will meet such requirements imposed by the duties of the job. . . .

The 15 staffs will move immediately to base hospitals in the event of attack to care for civilian casualties evacuated from danger zones to safer areas for convalescent treatment.

Hospitals Selected

Major Sebastian also stated tentative institutions for several base hospitals have been selected. The work of

surveying locations and institutions for base hospital use, their supply and maintenance is being worked out by Arthur J. Will, Director of Institutions for Los Angeles County and Southern Sector O.C.D. Hospital Officer.

These units, the major indicated, will be the nuclei of civilian casualty base hospital staffs.—Los Angeles Times, September 6.

* * *

Blood Bank of Red Cross Honored

Army and Navy 'E' Awarded for Work of Group

In colorful ceremonies climaxed by the raising of the pennant over the center by a soldier and a sailor who owe their lives to Red Cross blood plasma, the Army-Navy "E" for excellence was presented today to the Red Cross Blood Procurement Center, at 2415 Jones Street.

A crowd of 500 persons attended the ceremonies, held in the patio of the California School of Fine Arts.

Presenting the pennant was Brigadier General Frank W. Weed, and accepting for the chapter, Frederick J. Koster, chairman of the board.

Representing the Navy was Captain E. U. Reed, who presented the accompanying emblem, which was accepted by Mrs. Gardiner Dailey, director of the blood bank.—San Francisco Call-Bulletin, September 30.

* * *

OCD Organizes Doctors' Units to Care for Invalids

Director James C. Sheppard and Medical Officer Fred T. Foard of the Ninth Regional Office of Civilian Defense, were advised yesterday by National OCD Director James Landis, that units of physicians are being organized to help care for hospital patients who, in case of enemy action, would be moved to emergency hospitals, according to an announcement yesterday.

Now being established in selected medical schools and hospitals in the coastal States, the physicians units are part of the joint program of the civilian population.

The physicians, who will receive commissions in the U. S. Public Health Service Reserve, will be called to active duty only if hospital patients in their own regions must be moved to emergency hospitals.—San Francisco Chronicle, September 7.

* * *

O.C.D. Appoints Unit Directors of Casualty Hospital Staffs in Los Angeles

Twelve Doctors Connected With Leading Southland Medical Institutions Named to Posts

Unit directors of civilian casualty base hospital staffs who will have organized medical men ready for instant operation in the event the Southland is attacked have been nominated from the staffs of 12 Southern California medical institutions.

This was announced at the Office of Civilian Defense in Pasadena yesterday.

The nominees and institutions are: Drs. George Piness, Cedars of Lebanon Hospital; Sidney R. Burnat, Good Samaritan; Philip J. Cunnane, General; E. Forrest Boyd, Olmstead Memorial Presbyterian; Donald Cass, Queen of the Angels, and Charles T. Sturgeon, S. C. School of Medicine, all of Los Angeles; Leroy B. Sherry, Huntington Memorial, Pasadena; William L. Cover, San Bernardino County Hospital; Bert A. Adams, San Diego County General; Clarence E. Rees, Mercy, San Diego; Hugh Freidell, Santa Barbara Cottage; Ralph W. Homer, Ventura County Hospital.

Each man eventually will be commissioned the equivalent of a lieutenant colonel in the United States Public Health Service and is charged with the responsibility of organizing a staff of 14 medical men for each unit director.

Hospital Facilities for Raids Checked

Los Angeles is assured of ample hospital facilities in case of air-raid casualties.

This was the statement made to a joint meeting of city and county civilian defense officials yesterday in Mayor Bowron's office by Arthur J. Will, chairman of the augmented city and county hospital committee.

Will reported that 5700 hospital beds would be available in the city and county, with immediately contiguous areas providing 300 more, the 6000-bed total being twice the amount of hospital facilities recommended as standard by the Federal Office of Civilian Defense. The hospital committee chairman said additionally that this city would not have to use hotels, apartment or other makeshift hospitalization plans.—Los Angeles Times, October 3.

* * *

Yorktown Officer Praises 'Iron Men'

Sailors Amazing in Bravery, Endurance, Skill and Spirit, Dixie Kiefer Declares

Has the Navy, in superseding its towering frigates with

the modern steel, steam-propelled speedsters of the sea, also sacrificed its traditional "iron men" who manned the cannonades and rigged the boarding nettings in the service's glorious past?

"Hell—no!" exploded chunky Comdr. Dixie Kiefer, executive officer of the carrier U.S.S. Yorktown, which sank following the Midway victory over a Jap invasion armada, as he hobbled yesterday about the living room of his sister's home at 637 N. Crescent Heights Blvd.

Ankle Shattered

Comdr. Kiefer, whose right ankle was shattered in a fall against the rolling chocks of the listing carrier as he abandoned ship—one of the last to do so—is alternating between Los Angeles and the Mare Island Naval Hospital, where he is undergoing treatment.

"Let me tell you something, young man!" he exclaimed. "The 'wooden ships and iron men' era was long before my time, but the men who man the Navy's ships these days are absolutely amazing in their bravery, skill, endurance and spirit.

Examples Given

Why?—well, let me give you a few examples: . . .

Doctors Efficient

And a comforting note to mothers: "The Navy doctors—many of whom are volunteers and came into the service—are some of the best on earth. They're very efficient and have gained the confidence of all hands. They know their stuff.

"Well, if they didn't, I wouldn't have my right foot attached to me this very minute."—Los Angeles Times, October 2.

* * *

Oh, Doctor! No. 2

Behind the News: With Arthur Caylor

The doctors know a crisis when they see one, and they would like to do something about the shortage in medical and hospital care which is approaching San Francisco at the fast lope of galloping consumption. Hospitals are full. Doctors are going into the services. Trained nurses are getting as rare as crown jewels—and just as valuable. The Services are sure to take more of all three.

So the town is sure to find itself on a bed of pain, with no aid in sight—unless, as a municipality, it suddenly becomes as alert as the Services to look after its people. The Services are not only grabbing doctors, nurses and hospitals. They're going back into the country and taking over resorts to which convalescents can be shunted at the earliest possible moment—thereby clearing hospital beds. San Francisco should be doing something similar.

But this means the city must take up a new form of service to the people. Even with the best of intentions and the best of organization, the doctors can't supply hospitals, or back them up with convalescent homes, or train and pay nurses' aides. All this would require too much money. The city has the money. If other dough isn't available, it has millions of Civilian Defense money it can't spend. And medical service to the civilian population seems as much a CD necessity as bomb shelters.

With medical people of all sorts getting fewer, and thousands of others going to war, the population of California has grown 12 per cent since the 1940 census. It's scarcely possible to guess the rate at which this increase will continue. Doctors' offices and hospitals have filled up at an even faster rate than San Francisco's empty apartments.

You may not know this, but the doctors are going into the services under the regulations of the War Manpower Commission—not the Army, Navy or Selective Service. The Manpower Commission hopes to supply as many physicians as the Services demand—now 7.3 per 1000 or more than double the British provision—yet leave enough to meet minimum civilian needs. It is trying not to denude certain areas—especially rural districts. Since January, Dr. Harold Fletcher has been bucking this tough job. Note that it's a rationing job—so many doctors for the Services, so many for civilians.

On paper, it looks as if San Francisco is getting along—and will continue to get along until the Services reach nine million. Yet Dr. J. C. Geiger, the city's health officer, is just back on the job after a bout with bronchial pneumonia which he went through at home because he couldn't get into a hospital. He tried, but no soap. So what chance for an ordinary bloke? Better take that home-nursing course, sister.

Maj. Gen. Lewis B. Hershey, head of Selective Service, says the armed forces will reach 13 millions next year—and that's a way over nine million. His information is of the best. So why fool around? These next-year crises have a habit of arriving before Thanksgiving. Smart mothers-to-be already are signing up for hospitals next

April—or practically before they begin to wonder.

By summer, maternity wards may be the really exclusive clubs. Only, by that time all the obstetricians may have gone into collapse—or have joined the Army to get a rest. Why? Because any known doctor can deliver a baby. Practically every doctor who joins up has a baby or two on the way. So he tells Mrs. Jones to see Dr. Twerp, a good baby man. The result is that the obstetricians are doing their own work and that of several hundred other doctors. When somebody mentions an assembly line, 40 hours, or overtime, they laugh fit to kill.

I mention this particular department of medical affairs only because it's the last department you'd expect to be affected. Others are as bad off—just getting along "as well as can be expected." Everywhere you can see evidence that when Chief Administrative Officer Brooks, Health Director Geiger and Institutions Director Wollenberg go into the matter—as they propose to do—they'll find a need for action which starts now.

You may argue that if the boys can die in the Solomons and over the Ruhr and in Africa, we can get along without doctors. I heard a story the other day which makes one feel that way. The general and his staff went out from headquarters of a militarily secret airfield to inspect night protection measures. When they returned every man they had left behind was dead—cut down by a Jap infiltration party. The radio was blating over their twisted bodies that folks back home were being asked to eat less meat!

Still, it seems senseless not to make the most of whatever is left to us. And that means the city must help with organization and money and planning. There's no particular point in letting some San Francisco soldier's wife or mother die because we're unable to use the full capacity of the doctors, nurses and hospitals still on hand. Worse, if we don't make the best use of the doctors, nurses and hospitals we are allotted, it will simply mean fewer doctors, nurses and hospitals can be rationed to the armed forces. Doctors will be pulled away from the Services to take care of civilians. There's no percentage in that.—San Francisco News, October 8.

* * *

Women Doctors in WAAC

Washington, Sept. 8.—(AP.)—Increased opportunities for women, including women doctors, were forecast today by Mrs. Oveta Culp Hobby, director of the WAACS, and Lieut. Comdr. Mildred McAfee, head of the WAVES. They were guests of the Women's National Press Club. . .

Miss McAfee said the WAVES program is expanding from the originally intended 1,000 officers and 10,000 sailorettes. In addition to 900 officer candidates who will begin training at Smith College on October 6, 300 will be trained at Mt. Holyoke College.

The law creating the Women's Auxiliary Army Corps permits 150,000 women to volunteer for noncombat service, and President Roosevelt in signing the bill limited the number to 25,000 at present. Mrs. Hobby reported this goal would be reached by May.

No limit was placed on the number in the Women's Naval Reserve, and Miss McAfee said the presumption is that the demand for women to replace men in non-combat shore jobs will go much past the original estimate.

At present the WAVES cannot serve outside the continental United States, but this does not apply to the WAACs, and Mrs. Hobby said it is contemplated that four company headquarters of WAACs will go to England this year. She said almost 90 per cent of the WAACs express preference for overseas duty.—San Francisco Examiner, September 9.

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Heroic Doctor of Ill-Fated Lexington Gets Naval Cross

Commander From Little Ohio Town Refused to Quit Ship Until Patients Moved Despite Serious Wounds

Annapolis (Md.) Sept. 9.—(AP.)—Comdr. Arthur J. White, one of World War II's previously undisclosed naval heroes and a survivor of the ill-fated aircraft carrier Lexington, today received the Naval Cross during simple ceremonies at the Naval Academy.

One of the Lexington's senior medical officers, White was cited for his refusal to abandon ship although both his ankles and a shoulder were fractured and numerous wounds were inflicted by two thunderous explosions which shattered the stricken carrier in the Coral Sea.

While Japanese torpedo planes and dive bombers dumped their lethal loads on and about the Lexington, the middle-aged doctor, hailing from little West Leipsic, O., transferred his wounded and dying patients from a shattered dressing station and thence to a rescue ship before leaving his post.

White first was wounded when a blast all but destroyed

the flimsy dressing station he directed, blowing metal and debris about him. This was the first of two explosions which hastened the Lexington's end.

Covered with blood and hobbling about on his broken limbs, White transferred his patients to another improvised station, but then had to abandon these quarters when the second blast came.

Although the carrier was swathed in flames, White shunned all his subordinates' entreaties to quit his post. Only after his final patient was removed did he consent to be lowered to the rescue ship.

The medal was presented by Rear Admiral John R. Beardall, Navy Academy superintendent, acting for Navy Secretary Knox on behalf of President Roosevelt. Now stationed at the United States Naval Hospital here, White received the award while the entire hospital corps looked on.—San Francisco Examiner, September 10.

* * *

Afflicted Will Not Endanger Soldiers

Chicago, Sept. 17.—(AP.)—Wives and mothers of service men were assured today by Dr. Morris Fishbein of the American Medical Association that proposed induction of some men with venereal diseases would not jeopardize the health of others.

Major General Lewis B. Hershey, national selective service director, announced Tuesday the army has agreed to take some men with venereal diseases, starting in October. Of the proposal, Dr. Fishbein, editor of the Association's journal, said:

The induction of men with curable venereal diseases cannot possibly be hazardous to the health of those in the army since such men are assigned promptly for treatment and are under control.

Certainly the presences of recently acquired syphilis or gonorrhea should not enable a selectee to avoid military service. Modern scientific diagnosis and treatment, including new drugs and new methods, applied to rehabilitation of such infected men could supply the army promptly with from 80,000 to 100,000 additional soldiers.

Already many of the best known specialists in the field of venereal diseases have been commissioned in the army and navy medical departments and in that of the air force. These officers and the guidance of the scientific consultants in the Committee on Venereal Diseases of the Division of Medical Sciences of the National Research Council will assure to those infected the best and the latest that scientific medicine has established as useful in such cases.—Sacramento Bee, September 17.

* * *

Victory Must Be Total

Bethesda, Md., Aug. 31.—(AP.)—President Roosevelt dedicated a monumental new naval hospital here today with an assertion that America was wholly dedicated to the defeat of German, Italian, and Japanese tyrants and "to the removal from this earth of the injustices and inequalities which create such tyrants and breed new wars."

He spoke from a platform in front of the white, 270-foot-high section of the new naval medical center and the radio carried his words to all parts of the world by short wave.

Hospital a Symbol

"Let this hospital then stand," he said, "for all men to see throughout the years, as a monument to our determination to work and to fight until the time comes when the human race shall have that true health in body and mind and spirit which can be realized only in a climate of equity and faith." . . .

The center which the president personally helped design was dedicated on the 100th anniversary of the establishment of the navy's bureau of medicine and surgery, and the chief executive pointed to the vital work that the doctors and nurses of the bureau are accomplishing in keeping physically fit the men who man the fighting ships.—Visalia Times-Delta, August 31.

If you choose to represent the various parts in life by holes upon a table, of different shapes—some circular, some triangular, some square, some oblong—and the persons acting these parts by bits of wood of similar shapes, we shall generally find that the triangular person has got into the square hole, the oblong into the triangular, and a square person has squeezed himself into the round hole. The officer and the office, the doer and the thing done, seldom fit so exactly that we can say they were almost made for each other.

—Sydney Smith, *Sketches of Moral Philosophy*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.

American Medical Association, San Francisco. Date of 1943 Session not yet decided.

The Platform of the American Medical Association

The American Medical Association advocates:

1. The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

8. Expansion of public health and medical services consistent with the American system of democracy.

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a.m., under the title "Your Doctor and You."

In October KFAC will present these broadcasts on dates of October 3, 10, 17, 24 and 31.

The Saturday broadcasts of KECA are given at 10:30 a.m., under the title "The Road of Health."

†In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

*County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Pharmacological Items of Potential Interest to Clinicians*

Author's Note: Some 400 copies of this bulletin have been distributed from San Francisco monthly for the past 3 years to friends all over the world (and lots have been returned undelivered, lately). Now we are moving to Texas. If possible, these will continue to be sent around monthly, at least to such friends as wish them. They may also be published in such medical periodicals as may wish to use them. It'll be good to hear from you: write *University of Texas Medical School, Galveston, Texas*.

1. *More War Medicine Books:* Information Center (505 5th Ave., N. Y.), issues *Medical War Books Directory* for 1939-42. AAAS publishes symposium on *Relapsing Fever in the Americas*. C. C. Thomas (Springfield, Ill.) goes places, as usual, with S. Mudd and Wm. Thalhimer's fine *Blood Substitutes and Blood Transfusions* (Bill Thalhimer tried a blood bank in Milwaukee in 1926—got some minor reactions, stopped! A. S. Wiener's *Blood Groups, Transfusion and Plasma*, and J. B. Herrick's pleasant *Short History of Cardiology*.

2. *More War Medicine:* April issue *Bull. Amer. Coll. Surg.* (Vol. 27, No. 2), is devoted to panel discussions on war medicine. May issue *Arch. Surg.* (Vol. 44, No. 5), contains a symposium on gunshot wounds, burns and shock. A. B. Sirbu and A. M. Palmer, *Calif. West. Med.*, 57:123, 1942), offer pertinent report on march fractures. J. H. Woolsey (*Ibid.*, p. 130), gives excellent discussion on soft tissue war wounds and complications. D. L. Lynch describes effects of war on industrial health (*N. Eng. J. Med.*, 227:209, Aug. 6, 1942).

3. *More from Military Medical Services:* S. P. M. Bushby and L. E. H. Whitby describe large scale production of nonclotting plasma (*J. Roy. Army Med. Corps*, 78:255, 1942). A. I. L. Maitland discusses war burns (*J. Roy. Nav. Med. Serv.*, 28:3, 1942). E. P. Ellis recommends improvised methods for oxygen administration (*Ibid.*, p. 125). A. F. Abt suggests that ascorbic acid administration may prevent arsenical reactions (*U. S. Nav. Med. Bull.*, 40:291, 1942). J. Felsen discusses control of infectious diarrheas (*Mil. Surg.*, 91:65, 1942). C. M. Kos notes otolaryngological problems in aviation medicine (*Texas St. J. Med.*, 38:280, 1942).

4. *On Physiology:* J. Nedham, et al, ask if muscle contraction is an enzyme-substrate reaction (*Nature*, 150:46, July 11, 1942). M. Valentinuzzi and E. M. Busconi give remarkable mathematical analysis of cooling power co-efficient of body in relation to surrounding temperature (*Rev. Med. Lat. Amer.*, 27:682, 1942). H. M. Winans, J. V. Goode and C. T. Ashworth observe ventricular strain from compression of the pulmonary artery (*South Med. J.*, 35:225, 1942). G. J. Martin, M. R. Thompson and J. Carvajal-Forero show pantothenic acid and inositol essential for normal gastro-enteric motility with pylorospasm, hypertonicity, hypomotility, and gas resulting from deficiency. (*Amer. J. Dig. Dis.*, 9:268, 1942).

5. *On Bacteriology, Protozoology and Chemotherapy:* E. C. Rosenow discusses alpha streptococci in phase rela-

*These items submitted by Channcey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

tions to virus diseases (*Amer. J. Clin. Path.*, 12:338, 1942). F. M. Burnet immunizes against influenza virus B with living attenuated product (*Med. J. Austral.*, 1:673, June 20, 1942). J. B. McNaught thoroughly covers trichinosis (*Texas St. J. Med.*, 38:252, 255, 1942). Ann Bishop gives excellent review of chemotherapy and avian malaris (*Parasit.*, 34:1, 1942). H. King and W. I. Strangeways discuss relation between chemical structure and drug resistance among arsenicals (*Ann. Trop. Med. Parasit.*, 36:47, 1942). F. G. Perrz-Carral and E. B. Loreno find that sulfathiazol produces local inflammatory reactions on intraperitoneal application (*Rev. Med. Hosp. Gen. Mex.*, 5:839, 1942).

6. *Eyepener*: Studies on grafted nerves by F. K. Sanders and J. Z. Young (*J. Anat.*, 76:143, 1942), and fibrin suture of nerves by H. J. Sedden and P. B. Medawar (*Lancet* 2:87, July 25, 1942).

Doctors of Medicine as Some Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared on pages 108-109 of the July issue of CALIFORNIA AND WESTERN MEDICINE. Some recent excerpts follow:

* * *

SPARE YOUR DOCTOR

War's drain on the nation's doctors continues to grow rapidly. In time, it is likely that all physically fit younger doctors, and many older doctors, will be called to military service. And so, the burden of work on the doctors who remain at home will be doubled and redoubled.

Many authorities are now advising the public as to how it may help these doctors perform their job with maximum efficiency under difficult conditions. First, don't ask your doctor to make a house call if you are able to go to his office. Second, don't call him at inconvenient times unless there is an emergency. Third, when you do see him, don't waste his time in gossip and idle talk. It may be all right to "visit" with the doctor in normal times—it is definitely a bad practice now.

The standards of American medical care are the highest in the world. During the war, with millions of people working at arduous labor, every possible means of guarding and maintaining these standards must be used. And you can be certain that the doctors will do their part. They will willingly work longer and harder. They won't spare themselves. They know better than anyone else that the preservation of civilian health is absolutely vital to the war effort.

The patient who wastes a doctor's time may, unwittingly, be depriving a person who desperately needs it, of medical attention. Spare your doctor!—San Mateo *Times and Leader*, September 8.

* * *

MAINTAINING MEDICAL STANDARDS

American medicine is doing everything in its power to meet the enormous demand of war for physicians. It is assisting the military forces in swiftly obtaining the doctors and dentists they need. As a war measure, the medical schools of the country have increased the size of their entering classes by about 10 per cent, and have adopted an accelerated program which calls for the graduation of a class every nine months. In addition, the bulk of the medical schools are now making available

for military service all members of their faculties except those who are absolutely essential.

The purpose of this medical program is two-fold. First, the Army and Navy must be provided with sufficient men of medicine. Second, and equally important, there must be no deterioration in the standards of medical instruction. It is obvious to anyone that a badly-schooled or underschooled doctor would be a definite danger to the community in which he might practice. As a result, medical groups have insisted that the medical schools maintain their standards—and the government authorities have wisely coöperated.

A "speed up" in medical education can only go so far. There is a definite limit beyond which the time necessary for education cannot be reduced. The future welfare of this country demands the highest possible standards of medical care and service—and American medicine will see that those standards are maintained.—Oakland *Inter City Express*, September 4.

* * *

KEEP FIT, BECAUSE ILLNESS IS GOING TO BE LESS CONVENIENT SOON

One fact born of the war which has not yet been fully grasped by the civilian population is the increasing necessity of remaining healthy. Feeling fit is no longer just a beautiful principle, chiefly championed by the loincloth muscle men who peer at readers from the advertisements in magazines. Feeling fit is not just a patriotic responsibility. Feeling fit is about the only thing which will make one immune from the rapidly growing shortage of civilian doctors and physicians at a time when the task of getting a hospital room will be on a par with the last-minute, peace-time scramble for Labor Day accommodations at one's favorite resort.

* * *

One has only to poll the list of one's personal acquaintanceships within the medical profession to be impressed with the number of doctors and surgeons who have enrolled, or are about to enroll in the armed services. The burden of responsibility for the welfare of the civilian population already is falling heavily upon older men, particularly those whose years-cemented clientele has grown to proportions requiring a staff of one or more younger doctors. While the younger, newer men may possess even greater skill than their senior partner, it is common experience that long-time patients prefer to wait, even days at a time, for an appointment with their "friend." For years this has been true. Now, with the right and left commissioning of these younger men, many of whom also make real and patriotic sacrifices in entering service, the above-military-age doctors and surgeons are carrying tremendously increased loads.

* * *

Project this trend a few more months, let alone years, and the premium upon feeling fit really will be clear. There will not be doctors who arrive at the door a few moments after an emergency phone call. Appointments will be harder to get, unless the case obviously is critical. And instead of daily visits to private homes in widely separated locations, the patients will go to a hospital where a doctor can merely walk down the corridor and treat them all—that is, if the hospital is not already jam-packed.

* * *

To write this is not alarmist. Thoughts expressed here are those running through the minds of many, above-military-age medical men now working to the hilt. But this picture is worth serious consideration by all who have taken good health for granted, and so have failed to practice the health-preserving rules of exercise, regular sleep, wholesome food and worry-free mental discipline. They should take note. Because in 1943 it's going to be

a lot more unpleasant to be ill than it is right now. And the well had better stay well so that the unavoidably ill will have a maximum chance for prompt, skilled and adequate help.—*Pasadena Star-News*, August 28.

* * *

WE MUST AVOID UNREASONABLE DEMANDS ON DOCTORS' TIME

Paul V. McNutt, chairman of the War Manpower Board, recently pointed out that unreasonable demands on physicians' time must be avoided.

The necessity for this is apparent. Thousands of doctors have entered military service. By the end of this year, 20,000 additional physicians will be needed to serve our men in uniform. That need must be met, and it will be met. And one inevitable result will be a sharp decline in the number of doctors available to serve civilians.

This does not mean that anyone will have to go without necessary medical attention. It does mean that all must help, so far as they can, to see that doctors are able to use their working time to the fullest advantage. To quote Mr. McNutt, on the doctor's part: "It will mean long hours and hard work—sacrifices which will multiply the deep debt that every community owes to its physicians. There will be a real need to exercise every possible means for minimizing unnecessary medical services."

In other words, you are asked to forego for the duration the "luxury" of wasting your doctor's time and energies. That is a real and necessary contribution to the war effort, and to the protection of civilian health as well.—*Martinez Gazette*, August 20.

* * *

MEDICAL PROGRESS NEVER ENDS

The steady progress American medicine is making against the dread bacterial killers, is illustrated by some figures concerning typhoid which were recently published in the *Journal of the American Medical Association*.

Last year, this report says, there was a significant decrease in the typhoid death toll in the large cities of the country. In 1940, there were 24 cities with typhoid death rates exceeding one per hundred thousand population—and in 1941, there were only 11 such cities. And for the 78 cities for which data is available since 1910, the 1941 death total was the lowest on record.

What is true of typhoid is true of a long list of other diseases. Typhus, tuberculosis, pneumonia, yellow fever—these are but a few of the killers which American medicine is defeating. In almost every case, the death rates are declining.

All of us have heard of famous doctors who have made spectacular medical discoveries. But doctors whose names are virtually unknown, deserve a great share of the credit for medical progress. The fight against disease goes on in backwoods communities, no less than in shining research laboratories with the finest equipment money can buy. Obscure general practitioners are doing their part, no less than the most distinguished specialists. In American medicine, progress never ends—and each achievement is simply a challenge to greater achievements yet to come. America has reason to be proud of its doctors.—*Nogales Herald*, September 17.

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THE VANISHING DOCTOR

"The medical profession is closer to scraping the bottom of the bucket than any other occupation, trade and profession." So said last January Dr. Morris Fishbein, whose position as editor of the *Journal of the American Medical Association*, put him in a position to know. . . .

To cope with this situation some steps are being taken

which, if long continued, would mean danger in the future. Internships are being lowered, in many places, from two years to one, and some medical schools are cutting their courses from four years to three. Such changes have to be made because the call is great by the armed forces. It behooves all civilians to use their utmost to keep themselves in condition so that it will not be necessary to "call the doctor." . . . —*Riverside Enterprise*, September 18.

Physicians Wanted for Los Angeles County Tuberculosis Unit.—The Los Angeles County Civil Service Commission is seeking Physicians, M.D.'s, who are at least 21 years of age, for positions in the Olive View Sanatorium as Physician, M. D. (Tuberculosis) and Assistant Physician, M. D. (Tuberculosis). Physicians who have completed one year of internship in an approved hospital may file an application for the position of Assistant Physician. Doctors with one year's recent experience in the practice of medicine may apply for the Physician position.

There will be no written examination. Candidates will be rated on their scholastic record in medical school, their internship record and their aptitude and suitability for the advanced training, as evidenced by investigation or interview.

Qualified persons over 55 may file for the position of Physician for "Duration" appointments. All interested persons, whether residents of Los Angeles County or not, should obtain complete information from the office of the Commission, Rm. 102, Hall of Records, in Los Angeles, on or before Tuesday, October 13, 1942.

Resident Physicians in Nine Specialties Wanted in Los Angeles County Hospital.—Physicians at least 21 years of age, with an M.D. degree from an approved medical school and the completion of a one-year internship in an approved hospital, are being sought by the Los Angeles County Civil Service Commission, for the position of Resident Physician, M.D., in the Los Angeles County General Hospital, in the specialties of Anesthesiology, Dermatology and Syphilology, General Medicine, Neuro-Medicine, Neuro-Surgery, Ophthalmology, Orthopedic Surgery, Otorhinolaryngology or Pathology.

There will be no written examination. Candidates will be rated on their medical training and experience and their aptitude and personal suitability for advanced training in the specialty for which application is made.

Interested persons, whether residents of Los Angeles County or not, should obtain complete information from the Los Angeles County Civil Service Commission, Rm. 102, Hall of Records, in Los Angeles, on or before Saturday, October 17, 1942.

American College of Physicians.—At the Annual Meeting of the American College of Physicians, held in Atlantic City, June 6-8, 1942, John C. Sharpe, M. D., of Salinas, was elected a member of the Board of Governors of the College.

Interesting scientific programs were presented at the meeting and constructive plans laid out for the future.

Long Service of Departmental Employees in State Board of Health.—A study of personnel records of the California State Department of Public Health reveals the fact that 41 employees have served the department for 15 years and more, and 24 employees have served for 20 years and over. Eleven employees have served for 25 years and more, and 3 employees have served for more than 30 years. One employee has served since 1908. It is

believed that few State governmental units have such long service records as this department.

National Foundation for Infantile Paralysis.—The Third Annual Medical Meeting of the National Foundation for Infantile Paralysis, 120 Broadway, New York, will be held in New York City, on December 3-4, inclusive.

Graduates of Schools of Osteopathy Registered by Medical Examining Boards, 1934-1939.—The number of graduates of schools of osteopathy granted the privilege of practicing medicine, surgery or both by the medical examining boards from 1934 to 1939, inclusive, are given in table 22. Osteopaths licensed as physicians and surgeons by osteopathic boards, as for example those in California, are not included in these statistics.

In 1939, seven states registered such individuals, ninety-eight by examination and twenty by endorsement of credentials, namely in Colorado, Connecticut, Massachusetts, New Jersey, Oregon, Texas and Wyoming. These facts are shown graphically in chart 2 on page 1656, indicating by shaded lines those registering fewer than six graduates and by a solid area those licensing more than five such candidates during 1939.

In the six-year period, 1934-1939, 664 graduates of osteopathic schools secured licenses to practice medicine, surgery or both. Texas registered 273, New Jersey 145, Colorado 98 and Massachusetts 76; other states fewer than 20.

In Colorado, osteopaths have no separate board. They are admitted to the examination for a license to practice medicine. The statute of Colorado is silent with respect to the scope of practice authorized by a license issued to osteopaths.

In Connecticut, statute provides that any registered osteopath may practice either medicine, surgery or both, as the case may be, after passing a satisfactory examination before the medical examining board.

The Massachusetts statute, by definition, includes osteopathy in the practice of medicine and does not differentiate the type of license issued to an osteopathic applicant. The medical practice act requires that any applicant for license to practice must be in possession of a degree of doctor of medicine, or its equivalent, from a legally chartered medical school that gives a full four year course of instruction of not less than thirty-two weeks in each year. An amendment to the medical practice act providing an approving authority is not yet effective.

In New Hampshire osteopaths are granted the right to practice medicine and surgery by the Board of Registration in Medicine.

Osteopaths who are duly registered and licensed to practice osteopathy in the state of New Jersey, who present three years of practice of surgery in a hospital approved by the Board of Medical Examiners, may be admitted to the examination to be licensed to practice medicine and surgery.

The statutes of Texas provide for the issuing of a license to practice medicine only. So far as the statutes indicate, the osteopaths are not restricted in their field of practice.

In the District of Columbia, Oregon, Virginia, Wisconsin and Wyoming, osteopaths are granted the right to practice surgery.

Salmon Lectures on Psychiatry and Mental Hygiene.—The Salmon Committee on Psychiatry and Mental Hygiene of the New York Academy of Medicine has named Dr. Emilio Mira, professor of psychiatry at the

University of Buenos Aires, Argentina, and formerly full professor of psychiatry at the University of Barcelona, Spain, as the Salmon Lecturer for 1942.

The lectures will be held on three successive Friday evenings, November 6, November 13, and November 20, in the New York Academy of Medicine Building, 2 East 103rd Street, New York City. Members of the medical profession and their friends are invited to attend.

The Salmon Committee each year selects an outstanding specialist in psychiatry, neurology or mental hygiene to deliver the series of lectures. Selection for the Salmon Lectureship is made from among the leading psychiatrists and neurologists throughout the world who have made the greatest contribution to their particular field of science during the preceding year and is likened to receiving the Pulitzer Prize in letters.

Stanford University School of Medicine: New Laboratory of Electroencephalography.—Western medicine was offered a new diagnostic service on October 8, 1942, with the formal opening of a new laboratory of electroencephalography at Stanford University's School of Medicine.

More popularly referred to as the "brain wave" machine, the electroencephalograph, as a sensitive and complicated electrical device for recording the electrical activity of the human brain, has been in use for several years, but the Stanford University medical investigators have installed what they believe to be one of the most complete and modern instruments in the country.

At present the new brain wave laboratory at Stanford is being used part of each day for testing by the military services.

The new instrument has been under construction and adjustment for nearly ten months. It is the outgrowth of several years of laboratory research work on convulsions and allied neurological problems which led to the need for such a precise method.

Dean L. R. Chandler of the Stanford School of Medicine regards the development as another example of a successful transition between the research laboratory, the "back room" of medicine, and practical clinical application.

The electroencephalograph just completed is unique among such apparatus in that it is entirely remotely controlled, thus avoiding electrical interference. It holds a newly-invented automatic calibrating device to give instant interpretation of the currents being recorded. The apparatus consists of four sets of amplifiers housed within a single unit.

On hand to watch the demonstration which marked the addition of the new department to Stanford Hospital's facilities were the directors of San Francisco's Irwin Foundation which has supported the project through its four years of progress from the research phase to fruition as a practical clinical method.

The Stanford staff, in making the diagnostic procedure available to western physicians, is receiving professional men for visits to the new laboratory.

With the new machine several portions of the brain may be investigated at one time and nearby and distant abnormalities may be studied simultaneously.

Supplemental Staffs for Emergency Base Hospitals.—Selected hospitals and medical schools in the coastal States have been invited by the Surgeon General of the U. S. Public Health Service to organize affiliated staff units which will be ready to serve when needed to supplement the medical staffs of Emergency Base Hospitals, now being designated by the Medical Division of the Office of Civilian Defense. These units resemble the affiliated hospital units of the Army except that they

are smaller in size. They are being organized in order to assure suitable status and remuneration for physicians who may be called upon in the event of an enemy attack in their locality to care for casualties and other patients who have been evacuated to the interior of their region. For additional information write to: Medical Division, Office of Civilian Defense, Washington, D. C., for copy of bulletin dated September 15, 1942.

Surgical Emergency Chests: Sacramento Outfit.

The Medical Division of the Sacramento Civilian Defense, in cooperation with Sacramento Chapter American Red Cross, recently issued a four-page leaflet describing Surgical Emergency Chests that are planned to carry supplies and equipment for as large a number and variety of cases as possible and still be portable. They may be used either as stationary units in the Casualty Station operating room or as mobile units to be taken to a site of disaster. The leaflet is well illustrated.

By removing the legs from the compartment at the bottom, placing them in the wells at the corners of the chest and setting the chest top in place, tables are provided.

The width of the chests permits them to be carried in the back of a car, either on the floor or seat, as well as in the trunk. The weight has been kept at a minimum so that they may easily be carried by two people.

Sliding trays are designed to hold the smaller or more fragile articles or those that would be needed quickly. The drug tray length is the width of the chest so that if the table top is crowded the tray may be placed by the sliding tray supports and still be convenient to use.

A Coleman kerosene lantern and a Coleman stove are carried in case gas or electricity is not available.

When packed the contents are so arranged that supplies needed first are at the top and some free space has been left should it be decided that other supplies or equipment should be added.

Auxiliary Ambulances.—The American Auxiliary Ambulances, Incorporated, Hotel Whitcomb, San Francisco, California, a nonprofit corporation was organized to assist Civilian Defense Committees in adequately preparing for possible enemy attacks or other disaster; and is featuring the U. S. Army and O. C. D. approved Auxiliary Ambulance Stretcher-Carrier unit. Station wagons and panel delivery trucks can be converted quickly, inexpensively, into safe and efficient auxiliary ambulances. The equipment was tested at Carlisle Barracks and approved by Surgeon General's Office U. S. Army; L. D. Gasser, Major General, U. S. Army War Department, Member of the Board for Civilian Protection, and George Baehr, M. D., Chief Medical Officer, Office of Civilian Defense. For further information, write as per address above.

U. C. Trains Workers for Public Health Program.

—A group of workers sent by public health officials to the University of California for special training have just completed an intensive eight-week course in sanitation problems and are returning to state and county posts.

Heightened interest in maintaining public health standards during the present emergency led Sacramento authorities to send 29 sanitation workers to the Berkeley campus for the purpose of studying special techniques in sanitary inspection, public health law, communicable diseases and their control, ventilation and housing, and sanitary engineering aspects of water, milk, and food supplies.

Under the direction of Dr. K. F. Meyer, chairman of the bacteriology department, both theoretical and practical aspects of the public sanitation program were pre-

sented in lectures, field trips, discussion groups, and laboratory practice. In addition to regular faculty members, special lecturers were called upon to give instruction in their specialized fields. Among these were chemists, inspectors, bacteriologists, and bureau chiefs from the state departments of public health and agriculture, representing such offices as the industrial hygiene service, the division of laboratories, the bureaus of dairy service and sanitary engineering, and others.

Medical Aid to Newcomers.—Newcomers to San Francisco may find reliable doctors through the County Medical Society's revised, up to date index of general practitioners and specialists, it was announced yesterday.

Although the Society urged the public to refrain from seeking unnecessary medical service at this time when the shortage of physicians is becoming acute, inquirers will be furnished a list of physicians by calling at 2180 Washington Street or phoning WALnut 6100.—San Francisco *Examiner*, October 5.

New Journal: "Gastroenterology."—The American Gastroenterological Association on January 1, 1943, will publish the first issue of a new Journal to be called, *Gastroenterology*. The new Journal will be owned by the Association, will be the official publication of the Association, and will be published by William and Wilkins Company. It will appear monthly, and the subscription price will be \$6.00 per year.

Dr. W. C. Alvarez will be the editor (after June, 1943) and Dr. A. C. Ivy will be the assistant editor. Dwight L. Wilbur of San Francisco is a member of the editorial board. *Gastroenterology* invites for publication clinical and investigative contributions which are of interest to the general practitioner as well as the specialist and which deal with the diseases of digestion and nutrition, including their physiological, biochemical, pathological, parasitological, radiological and surgical aspects. Manuscripts should be sent to Dr. A. C. Ivy, c/o *Gastroenterology*, 303 East Chicago Avenue, Chicago, Illinois.

American Public Health Association.—In connection with the 71st Annual Meeting of the American Public Health Association in St. Louis, October 27-30, meetings of the following related organizations will be held:

- American Association of State Registration Executives.
- American School Health Association.
- American Social Hygiene Association.
- Associated Teachers of Preventive Medicine.
- Association of Women in Public Health.
- Conference of Municipal Public Health Engineers.
- Conference of State Directors of Health Education.
- Conference of State Directors of Public Health Nursing.
- Conference of State Directors of Local Health Services.
- Conference of State Nurse Deputies.
- Conference of State and Provincial Public Health Authorities and Association of State and Territorial Health Officers.
- Conference of State and Provincial Public Health Laboratory Directors.
- Conference of State Sanitary Engineers.
- Illinois Conference on Public Health.
- Illinois Public Health Association.
- International Association of Milk Sanitarians.
- International Society of Medical Health Officers.
- National Committee of Health Council Executives.
- National Organization for Public Health Nursing.
- National Society for the Prevention of Blindness, Inc.

The advance programs, as published in the American Journal of Public Health, show close relationship to wartime health problems. Nutrition, industrial hygiene, the control of communicable diseases, maternal and child health, and housing are among the aspects of civilian health to be discussed by the several hundred speakers. The health protection of the armed forces will be described by high officials of the Army and the Navy.

2,500,000 Pints of Blood Needed By U. S. in Year.

—Blood donors are needed at the rate of 50,000 per week for the next 12 months, Chairman Norman H. Davis, of the American Red Cross, has announced. The Army and Navy have requested the Red Cross to collect a new quota of 2,500,000 pints of blood within that period.

The blood collected by the Red Cross will be processed into dried plasma and serum albumin for emergency transfusions for the armed forces. The serum albumin is a recently developed blood substitute in which the Navy is especially interested because it requires less storage space than plasma.

The Red Cross until now has had to restrict the quotas of its donor centers because of the limited capacities of the laboratories processing the blood. Laboratory capacity is being rapidly expanded, however, and will, with new ones soon to be participating in the program, have a combined capacity to process at least 2,500,000 pints of blood during the next 12 months and the total may reach 3,000,000.

The blood must reach a processing laboratory within 24 hours after it is drawn.

Those who have already given blood can do so again. The average healthy man or woman can safely give blood for transfusions every three months, according to a recent report to the American Medical Association.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Doctors Cancel S. F. National Convention

Chicago, Sept. 18.—(INS.)—The American Medical Association announced today cancellation of its ninety-fourth annual session in 1943, which was to have been held in San Francisco, because of the "tremendous" wartime demands on the medical profession.

Instead of the general convention, the house of delegates, board of trustees, scientific councils, and officials of the association will meet in Chicago in June, 1943, chiefly to consider the profession's wartime problems.—Fresno *Bee*, September 18.

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Medical Men Drop 1943 Convention

Rumored for several months, the American Medical Association's abandonment of its 1943 national convention, slated for San Francisco, became official today.

The action was taken by the organization's board of trustees in Chicago, President C. E. Baen of the San Francisco Convention and Bureau was notified by Walter G. Swanson, bureau vice-president and general manager, who attempted to persuade the Association to go ahead with original plans.

Mr. Swanson said he was endeavoring to have San Francisco designated as the first convention city when the war is over.—San Francisco *News*, September 21.

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Chiropractors Ask Deferral

With a statement that the nation's armed forces have made no place for chiropractors, the International Chiropractors' Association has petitioned Lewis B. Hershey, selective service director, to recommend deferment of all members of the profession, Dr. Paul B. Firth, association representative here, announced Tuesday.

The petition pointed out that members of the profession, holding master's degrees in chemistry and other subjects, conferred by State universities, are automatically eliminated from serving in their specialized fields, because of "regulations written into the selective service act by organized medicine," Dr. Firth stated.

About 5 per cent of the chiropractor members are already in the service and at least 500 could be placed immediately in civilian communities, where they could serve on the home front by helping maintain national health and welfare, Dr. Firth pointed out.—Portland *Oregonian*, September 23.

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Caltech Again In Forefront In War Against Human Diseases

People of Pasadena and vicinity are proud in their possession of so distinguished an establishment for the

advancement of the sciences as the California Institute of Technology, and this pride is accelerated by every new achievement of the Institute and the earnest savants who carry on their researches there.

Latest kudos to the researchers at Caltech has just come from the Rockefeller Institute, and is bestowed upon Dr. Linus Pauling and Dr. Daniel H. Campbell of the Gates and Crellan Laboratories of Chemistry at Caltech. The bestowal is for their discovery of a new synthetic formula as an antibody against Type III pneumonia.

That the discoveries of these Caltech scientists, through painstaking experiment, promise to be of great benefit to mankind is indicated by discussion of their experiments in the Rockefeller Institute's publication, "Experimental Medicine," and affirmation of its practical value by the Journal of the American Medical Association.

Pneumonia, in its various forms, has long been one of man's most malignant scourges. The toll of this fever, down through the ages, has been appalling. Modern science, however, has made successful attack upon it. Use of oxygen tents and development of the efficacy of sulfa drugs have been noteworthy advances. And now it would appear that able Doctors Pauling and Campbell have written, out of their Caltech investigations, a brilliant new chapter of this progress. The Star-News congratulates them, and the Institute.—Pasadena *Star-News*, August 24.

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Texas Appoints Dr. Leake, U. C. Savant, As Dean

Austin, Tex., Aug. 22.—(AP.)—Dr. Chauncey Leake, 45, pharmacologist of the University of California Medical School, will become executive vice-president and dean of the University of Texas Medical Branch at Galveston about September 15.

Announcing Dr. Leake's appointment by the University Board of Regents, President Homer P. Rainey said regents, faculty and a special advisory committee agreed that "he is well suited for the position in Texas." Terms of Dr. Leake's contract were not disclosed.

As Dean he succeeds Dr. John W. Spies, recently discharged by the Regents, who also stripped department heads of administrative authority, effective September 1, as a result of administrative unrest at the school. The vice-president is a new position created by the Regents for the purpose of broadening the State's medical education program.

The medical branch has been placed on probation by the council on medical education and hospitals of the American Medical Association and appointment of Dr. Leake was considered another move directed at removing the probationary status, which impairs credits earned by students.—Oakland *Tribune*, August 23.

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Plenty of Doctors for All—If They're Called Soon Enough

A growing dearth of physicians which is resulting from demands of the armed forces need not seriously discommode the civilian population if citizens will call their doctor in the early stages of an illness, Dr. George M. Uhl, city health officer, said yesterday.

He cautioned against anxiety resulting from rumors that there will not be enough doctors to take care of the civilian population.

"If, during the day, you are not feeling well, call your doctor before nightfall," he advised.

The health officer said the situation could be relieved also by citizens going to their doctors' offices rather than insisting on calls at their homes.—Los Angeles *Daily News*, September 22.

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The Nation Calls the Doctor

The American Medical Association announces that approved medical schools, operating under accelerated wartime programs, will graduate a record total of 21,029 students during the next three years. The number is 5082 more than should normally have graduated. This increase is precious, and pitifully small. The man with the power of healing, with the power of preventing epidemic, is more important than the man trained to kill in this fight of the nation for its life.—Hanford *Sentinel*, August 27.

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Disease Quick Cure Assailed

Medical Officers Discount de Kruij

Local city and county health officers are in agreement with the American Medical Association journal in assailing an article titled, "One Day Cure for Syphilis," by Paul de Kruij which appeared in the September issue of *Readers' Digest*.

De Kruij is said to have jumped at conclusions regarding a treatment which still is admittedly in the experimental stage, and his article is assailed as having done

outright harm by raising false hopes and creating general dissatisfaction among venereal disease patients.

Drs. D. M. Bissell and C. M. Burchfield, city and county health officers respectively, have called attention to an article in the September 5 issue of the Medical Journal and to the work which is being done locally to combat venereal disease. . . .

That the present situation, according to Dr. Bissell, based upon accurate records over a long period of time, and de Kruij's sensational statements regarding new and experimental treatment contributes nothing constructive to the fight against this dread disease.—*San Jose Mercury Herald*, September 20.

* * *

Medical Aid for Housing Units Studied

The problem of providing adequate medical service to occupants of local U. S. housing projects with the present limited number of physicians was discussed last night at a symposium conducted by leading medical men of California during a meeting of the Solano County Medical Association at the Casa de Vallejo.

Executives of the California Medical Association attended together with leading physicians and surgeons of Solano County, Napa, San Francisco, northbay counties and Northern California.

The California Medical Association, working in conjunction with the Solano County group, is seeking a solution of the medical problem created by the large influx of defense workers to the greater Vallejo area and the shortage of doctors and lack of hospital facilities.

A definite program may result from the discussions now underway.

Attending last night's meeting were Dr. William Molony of Los Angeles, president of the California Medical Association; Dr. Karl Schaupp, of San Francisco, president-elect of the association; Dr. Henry Rogers, of Petaluma, past president; Dr. George Kress, San Francisco, secretary; John Hunton, executive secretary; Dr. John Green, of Vallejo, counselor for the ninth district; and Dr. Dwight Murray of Napa, chairman of the legislative committee of the state association.

More than 40 other physicians from Solano County and nearby cities and towns attended.

During the evening, a film was shown on new research in adrenal cortex extract, a new blood pressure raising principal.

Dr. Cary Snoddy, president of the Solano County Medical Association, presided at the meeting.—*Vallejo Times-Herald*, September 9.

* * *

Physician Takes Trip; Tires Will Be Seized

St. Louis, Sept. 4.—(AP.)—Tire rationing officials in Salt Lake City have been notified to intercept a St. Louis physician who is making a pleasure trip and confiscate four new rationed tires on his automobile.

Disclosure of the action was made today by Matt Morse, member of the St. Louis Rationing Board, who said the doctor was given a permit last week for the tires, which were to be used solely in driving to attend his patients.

The name of the physician was withheld by the board.—*Fresno Bee*, September 4.

* * *

Nevada Doctors Hear Addresses

Reno (Nev.), Sept. 25.—The Nevada State Medical Association entered the second day of its annual meeting here today after an opening session devoted to registration, inspection of exhibits of firms handling medical and surgical supplies, and listening to the annual address of President Dr. George Magee of Yerington.

Several visiting physicians spoke on technical subjects, including Dr. Robert A. Peers of Colfax, Calif., whose topic was "Control of Tuberculosis in the Individual Patient and Among His Contacts." The evening was given over to entertainment.

Papers scheduled for today, with discussions to follow, were those of Dr. Miley B. Wesson of San Francisco, Dr. George Warren Pierce of San Francisco, Dr. George Joyce Hall of Sacramento and Dr. Warren B. Allen of Oakland.

Dr. Horace J. Brown of Reno, who has been secretary of the Association for the last twenty-five years, announced today that he will retire from that position this year.—*Sacramento Bee*, September 25.

* * *

U. S. Population Set at 133,965,000 in '41

Washington, Sept. 28.—(AP.)—The war was given major credit by the census bureau today for a population increase of 1,327,000 in 1941, boosting the nation's esti-

mated population on January 1 to 133,965,000.

The 1941 increase, double the average for the previous ten years, was ascribed by the bureau largely to business prosperity due to war production, anticipation of being drafted and the return of Americans from other lands because of the war.

Births in 1941 rose to 2,728,000, about 408,000 more than the ten year average. Deaths during the year totaled 1,442,000, about average.

Because of a stoppage of immigration and an expected abrupt drop in the birth rate due to millions of men being in the armed forces, the bureau said, there was little prospect of continued population growth at the 1941 rate.

Women approached parity with men in the division by sexes, as the ratio of males per 100 females dropped from 100.7 to 100.4.—*San Francisco Call-Bulletin*, September 28.

* * *

Census Shows 22,000,000 Have Foreign Mother Tongue

Approximately 22,000,000 white persons in the United States have a foreign mother tongue, the Census Bureau announced in releasing the first data ever collected on the native language of the nation's population.

German was the mother tongue of more white persons in 1940 than any other language, yet German-speaking residents represented only about 4 per cent of the nation's white population, the bureau found. . . .

Spanish Third

A high percentage of the individuals whose mother tongue was Spanish are third and subsequent generation Americans. The Census Bureau remarked that "the speaking of Spanish has been retained quite tenaciously by the Mexican stock," which is concentrated in the southwestern section of the country.

California has 416,140 residents whose mother tongue is Spanish, the Census Bureau disclosed. The national total is 1,861,400, so that California accounts for 22 per cent. Spanish was reported as the native language of 1.6 per cent of the country's white population, the fourth highest on the list. . . .

The survey showed that English is the mother tongue of 93,039,640 white residents, or 78.6 per cent of the total. Other languages high on the list were German, spoken by 4,949,780; Italian, 3,766,820; Polish, 2,416,320; Spanish, 1,861,400; Yiddish, 1,751,100; and French, 1,412,060. No other foreign language was the mother tongue of more than 1,000,000 persons.

The census gave no figure on the number of persons for whom Japanese was the "mother tongue" since the study was confined to white residents.—*Los Angeles Times*, September 28.

* * *

U. S. Suicides Totaled 18,907 in 1940.

Census Bureau Reports

Three-fourths of All Persons Who Kill Themselves Are Males, Statistics Compiled by Department Show

Washington, Sept. 21.—(AP.)—Suicides totaled 18,907 in 1940, a rate of 14.4 for each 100,000 population, the Census Bureau reported today. This compared with a rate of 10.2 in 1900 and the peak of 17.4 in 1932.

The bureau offered these statistics about self-destruction:

More than three-fourths of suicides are males.

The ratio of white persons ending their lives is nearly four times as great as that of Negroes.

The Chinese ratio is highest of all—45.2 for each 100,000, while the Indian rate is 8.4 (refers to Chinese and Indians in America).

April has the highest suicide level, January the lowest.

Nevada has the highest rate—40.8 for each 100,000 population, while South Carolina and Arkansas tie at the bottom with a rate of 6.3.

The greatest number of suicides by age groups is in the 45 to 54 year bracket.—*Los Angeles Times*, September 22.

We American writers have one of the great stories of the world to tell, if we have the wit to tell it truly. There is no surer way that I know, of fitting ourselves for the future, than by gaining an understanding of what the ordinary citizen, who has to work for his living, has been doing and thinking and hoping through the course of formal history.—*Walter D. Edmonds*.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Physicians Leaving Practice During Present War: Status on Return as to Former Practice

In order to facilitate the participation of physicians and surgeons in the war effort, and to provide for adequate medical personnel for the various branches of the armed services, as well as for vital war industries and the civilian population, there was established on October 30, 1941, the Procurement and Assignment Service as one of the subdivisions of the Office of Defense Health and Welfare Service. This Procurement and Assignment Service relates to all physicians, dentists and veterinarians in the United States. The Service is to cooperate with the various offices of the selective service system in determining whether physicians, dentists, and veterinarians who are subject to classification by selective service are essential in their local communities or may be spared for service with the armed forces. In addition, various state committees will survey local needs for professional service, and on the basis of these surveys will determine how many physicians, dentists or veterinarians are needed in the various communities of the state to care for the civilian needs and how many can be released for service elsewhere.

All members of the professions to which the Procurement and Assignment Service applies are given an opportunity to express their preference for service in industrial practice, civil practice in other communities, state and local health departments and institutions, etc., in the event they are not eligible for service with the armed forces. As a result of the studies and work of this Service, undoubtedly there will be numerous physicians and surgeons requested to give up their remunerative practices in home communities to assist in the war effort in places where the need for medical men is greater. At the present time, there is no legal method of compelling a physician or surgeon to move from the community in which he is established or to accept duties in connection with a public health service or war industry. The procedure will be to request the particular physician and surgeon to make the change which the Procurement and Assignment Service deems necessary, and in the event of a refusal, the change cannot be compelled unless the physician is inducted into military service. All physicians and surgeons are subject to the provisions of the Selective Service and Training Act of 1940, and if within the designated age limits and possessed of the requisite physical qualifications, they can and will be drafted for service in the armed

forces unless it is determined that their services are necessary in their local communities or present position. Deferments on the basis of local need can be made only by the proper selective service authorities, but they are at present cooperating with the Procurement and Assignment Service in making determinations of the necessity of the particular individuals.

The great numbers of physicians and surgeons who will be taken into military service or transferred from their present locations by the Procurement and Assignment Service are all presented with the question of what their situation will be at the end of the war. The prospect of beginning anew to rebuild a practice which has been lost while the physician absented himself in the service of his country is not a bright one. With respect to individuals in private industry, Congress has afforded some measure of security in a section of the Army Reserve and Retired Personnel Service Law of 1940 (50 U.S.C.A. App. Sec. 403). It is therein provided that persons who leave positions in the employ of a private employer to enter military service shall be restored to such position or to a position of like seniority, status, and pay upon making application therefore on discharge from military service, unless the employer's circumstances have so changed as to make it impossible or unreasonable to do so. This makes it much more likely that such persons will not lose what economic advantages they had gained prior to the outbreak of the war. Unfortunately, there is no law which guarantees the return of their former practices to members of the professions on the termination of their military service or service with some other part of the war effort. From the very nature of the practice of physicians, surgeons, dentists or lawyers, etc., it would be impossible to draft any law guaranteeing the maintenance of their status while they are in the service of their country.

Obviously, if a physician or surgeons enters the military service or accepts a new position upon the request of the Procurement and Assignment Service, and makes no provision for the care of his practice while he is so occupied, there is no possibility of his maintaining any interest in the practice while on duty in another part of the country. There is nothing in law to prevent any physician and surgeon from establishing himself in the community abandoned by a physician entering military service, and continuing to practice in the same community at the end of the war. A man cannot be prevented from lawfully practicing his chosen profession in any community which he selects. Although the absence of a great number of physicians and surgeons serving in the armed forces may work to the advantage of those who remain, this is a situation which cannot legally be avoided. That some members of all professions will profit at the expense of those serving their country, must be expected, and is only one of the sacrifices which members of the medical profession will be called upon to make in the interest of national defense.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

It is possible, however, for a physician and surgeon entering military service, or responding to the call of the Procurement and Assignment Service, to enter into an express agreement with another physician to care for his practice until such time as he is able to return. In this manner a physician could maintain his offices in the care of the person selected to take his place, and on his return might still have some measure of his former practice. The details of the agreement which would be executed between the physician leaving and the person selected to take the position of *locum tenens* would be entirely up to the individuals. In order to protect the physician absenting himself, it could be provided that upon the termination of his war service the person taking his place should vacate the offices and such person could further expressly agree not to practice medicine in the same community for a period of years.

The question which immediately presents itself is whether or not such a covenant restraining a person from practicing his lawful profession would be valid. Obviously, if the physician who took the position of *locum tenens* could open other offices in the same community he might well take all of the practice with him of the physician who had been in military service.

Business and Professions Code, Section 16601, provides as follows:

"Any person who sells the good will of a business may agree with the buyer to refrain from carrying on a similar business within a specified county or counties, city or cities, or a part thereof, in which the business so sold has been carried on, so long as the buyer, or any person deriving title to the good will from him, carries on a like business therein."

In *Crutchett v. Lawton*, 139 Cal. App. 411, it was determined that this section applies to the sale of a physician's "office equipment, medical business and fixtures, including the good will of the business." In the *Crutchett* case, the District Court of Appeal held that a physician who had sold his practice could be enjoined and restrained from practicing his profession in certain counties of the state in violation of the covenant contained in his contract of sale.

Although the agreement contemplated above between a physician entering military service or leaving the community, and another physician who remains to care for the practice of the physician so leaving, is not strictly speaking a sale such as is contemplated by Business and Professions Code, Section 16601, quoted *supra*, the principle should be the same. In order that the contract and agreement be brought within the terms of this section it should provide that on the physician's return from military service his practice shall be transferred for a consideration and in effect sold back to him by the person in whose care it had been left, and further that as a part of the transfer such person covenants and promises not to engage thereafter in the practice of his profession in the same community. Such an agreement is in effect a partial sale, and the courts would probably hold that a covenant restraining the person in the position of *locum tenens* from practicing in the same community

after the return of the physician who has been in military service was enforceable. This result cannot be predicted with certainty but, in any event, it is advisable for all physicians leaving their communities to serve in the war effort to make some attempt to secure a person to maintain their practice during the period of absence, and also to enter into an express written contract with such person clearly defining their legal relations.

LETTERS †

Concerning Prizes in General Surgery: Offered by San Francisco Surgical Society

(COPY)

SAN FRANCISCO SURGICAL SOCIETY

September 21, 1942.

George H. Kress, M.D.

450 Sutter Street,

San Francisco, California.

Dear Doctor Kress:

The San Francisco Surgical Society wishes to announce an annual contest in the field of general surgery open to young physicians in San Francisco and vicinity. Two prizes are offered: first prize \$150 and second prize \$100.

The conditions of the contest are as follows:

1. The author must be a physician in the field of general surgery who is in the period of graduate training and not more than six years removed from graduation from medical school.
2. The author must reside (at least temporarily) within a radius of 50 miles of San Francisco.
3. The paper submitted must represent original work in the field of experimental or clinical surgery, but not necessarily based upon an original idea. The author may be aided by associates.
4. The paper must not have been presented or printed, as submitted in its final form, prior to submission to the Society.
5. All illustrations must be original and be provided with ample legends and identification marks to make them easily understood.
6. All references to the literature or other sources of information cited must be listed in a manner conforming to the abbreviations and order used by the Quarterly Cumulative Index Medicus. Diction, brevity and simplicity of written presentation will be considered factors of value.
7. The paper must be submitted without marks which would identify the author, hospital or institution of origin. A sealed, non-transparent envelope enclosing the name and address of the author must be furnished. The paper is to be sent to the Secretary of the Society and the return address must also be that of the Secretary of the Society. The Secretary will remove and retain the sealed envelope and transmit the paper to the Committee on Awards.
8. Prize winning papers will be presented by the authors at a meeting of the Society or an open meeting and in the manner designated by the Council of the Society.
9. Papers submitted must be in the hands of the Secretary not later than June 30, of each year.
10. If the papers be published, they shall be designated as the prize winning essays of the San Francisco Surgical Society.
11. A first prize of \$150 and a second prize of \$100 shall be awarded annually. If the papers submitted are not of proper standard, the Committee on Awards may

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

recommend that no award be made. Action by the Society shall be final.

Will you be kind enough to make some mention of this contest in CALIFORNIA AND WESTERN MEDICINE.

Very truly yours,
(Signed) JOHN W. CLINE, M.D., *Secretary*,
490 Post Street, San Francisco, Calif.

Concerning C.M.A. Donation to Lane Medical Library

(COPY)

Stanford University
Stanford University, California

September 23, 1942.

Dear Mr. Hunton:

I was much pleased to learn from Director van Patten of our University Libraries of the gift of \$1150 to our medical library for 1942 from the California Medical Association. This will be most helpful, and we are all much pleased by your generous support and to know that you feel our library has been of such assistance to members of the association.

With much appreciation for your kind letter and for your gift, I am,

Faithfully yours,
RAY LYMAN WILBUR, *Chancellor*.

Concerning C.M.A. Donation to Barlow Medical Library

LOS ANGELES COUNTY MEDICAL ASSOCIATION

September 29, 1942.

Dear Mr. Hunton:

Thanks very much for the check in the sum of \$1150.00 representing the contribution of the Association to our Library.

I want to assure you that our Library is receiving some very heavy demands for current literature from the various military posts throughout the State.

Yours very truly,
L. A. ALESEN, M.D., *Secretary*.

Concerning Library Material Connected with History of Medicine

(COPY)

UNIVERSITY OF CALIFORNIA

To the Editor.—The University of California Medical School wishes to call to your attention the fact that recently the Crummer Room of the History of Medicine has presented exhibits of material on the following subjects: History of Dermatology; Development of the Modern Pharmacopoeia; Contributions of Nineteenth Century French Clinicians.

The exhibit on Dermatology includes the first work on industrial diseases, the *Morbis Artificum Diatriba* of Bernardo Ramazzini, in which he describes not only the contemporary industrial diseases but discusses the conditions of industry at that time: the *Opera Omnia* of Fracastorius (1484-1553) who named syphilis: *Willan; On Cutaneous Diseases*, v. 1, 1809, the work which is the beginning of modern dermatology. This is the first American edition. Willan did not live to complete volume two. His work was taken up by Bateman, his disciple, who is represented by his *Delineations of Cutaneous Diseases*, 1828.

The exhibit of Pharmacopoeias traced the history of pharmacy from Egypt to the present day and included the *Dispensatorium of Valerius Cordus*, edition of 1592. This was the first legal pharmacopoeia to be printed. It was authorized by the Senate of Nuremberg in 1546. Also on view were the *De Medicinali Materia Libri Sex* of Pedacius Dioscorides, surgeon in the service of Nero

whose word was law in materia medica for sixteen centuries [edition of 1543]. Of national interest were the first edition of the *U. S. Pharmacopoeia* [1820]; the *Pharmacopoeia of the New York Hospital* [1816] and that of the *Massachusetts Medical Society* [1808]. Most important item of the exhibit was the *Pharmacopoeia Londenensis*, edition of 1618. This is a first edition of exceeding rarity.

The exhibit of the works of nineteenth century French clinicians was gathered together with the object of presenting the evidence of the great contributions made by the French nation to the advancement of science. An effort has been made to include as many branches of the medical arts as possible. Included are the first editions of *De l'Auscultation Médiate*, of Laennec [1819]; *Recherches Sur Les Effets de la Saignée* of Pierre Louis [1835], *Essai Sur les Maladies et les Lésions Organique du Coeur*, of Corvisart [1806]; *Examen Critique sur la Fermentation*, Pasteur's famous paper on Claude Bernard's theory; and *De la Paralysie* of Calmeil [1826]. Other men included in the exhibit are Magendie, Nelon, Dupuytren, Broca, Pinel and Charcot.

We would be grateful if you could find room for a short announcement of these exhibits in CALIFORNIA AND WESTERN MEDICINE.
U. C. Medical Center.

Sincerely,

FRANCES T. GARDNER,
Librarian, Crummer Room.

Concerning Lane Library Facilities

THE STANFORD UNIVERSITY LIBRARIES
Stanford University, California

August 24, 1942.

Dear Dr. Kress:

I believe that members of the California Medical Association will be interested in the present status of the Lane Medical Library's subscriptions to periodicals published in Germany and the occupied European countries.

The Joint Committee on Importations has approved in its entirety the list of periodicals which we considered essential to have for 1942. These periodicals have been paid for and will reach us in due course through approved channels.

If existing conditions continue, the more important periodicals issued in Germany and the occupied European countries for 1943 and later will be made available at the Lane Medical Library in microfilm form.

One or more microfilm readers will be available at the Lane Medical Library in September.

May I take this opportunity to express our appreciation of the assistance which we have received from the California Medical Association in the past.

Sincerely yours,

NATHAN VAN PATTEN, *Director*.

Concerning Licensure of Naturopaths in California (COPY)

1020 N Street, Room 536,
Sacramento, California, August 6, 1942.

Yours of July 20th, re: Naturopathic law.

American Naturopathic Association,
Anderson, South Carolina.

Attention: Dr. W. Gano Compers,
Secretary-Treasurer.

Gentlemen:

Your letter addressed to the Secretary of State has been forwarded to us for reply. Therein you request "a copy of the Naturopathic Practice Act as it is or was recorded on your statutes."

The only statutory provision relating to the practice of naturopathy ever passed in the State of California was Chapter 276, Statutes 1909, which required the Board of Medical Examiners to endorse certificates that had been issued by the Board of Examiners of the Association of Naturopaths of California without the requirement that the holder of such certificate should present any educational qualifications to the Board.

Under this amendment the Board was required to endorse some 103 certificates which had previously been issued by the Naturopathic Association of California. Such a naturopathic certificate was not valid in the State of California unless signed and sealed in 1909 by the then president and secretary of the Board of Medical Examiners, and said endorsement must have been made within the time required in the law.

Several ineffective attempts have been made in the past several years to pass a naturopathic law in this state.

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

CC George H. Kress, M. D., Secretary, C.M.A.

Concerning California Law in re: Graduates of Foreign Medical Schools

(COPY)

Sacramento, California,
August 20, 1942.

Subject: Yours of August 6th re: ———, M.D.,
Foreign medical school graduate.

Dr. ———,
Los Angeles, California.
Dear Doctor:

This will acknowledge receipt of your letter written in behalf of Dr. ———.

You undoubtedly are unaware of the statute passed by the 1941 legislature which exacted additional requirements of graduates of foreign medical schools.

The 1935 statute (Section 10) exacted that the foreign medical school graduate "must file evidence satisfactory to the Board that he has served at least one year in residence in a hospital located in the United States, approved by the Board for internship." Additional statutory requirements were exacted by the 1941 legislature.

Dr. ——— was familiar with these requirements. However, when he filed his application for written examination, he failed to produce evidence that he had fulfilled the requirements of the law. Although Dr. ——— showed residence in one of the State hospitals, none of the State hospitals is approved for the training of interns. Hence, he did not fulfil the statutory requirements. We regret Dr. ——— did not fulfil the statutory requirements; however, we have no suggestions to offer in this regard, as the Board of Medical Examiners administers the law only as passed by the legislature of this State.

Permit us to state that the records indicate that Dr. ——— has been in the State of California for a period of over two years. Sometime ago he was advised regarding the statutory requirements of graduates of foreign medical schools. During the period of his connection with the State hospitals he must have had sufficient time to train qualified practitioners of medicine in said hospitals so that they are able to administer scientifically the *insulin shock treatment*.

Awaiting your further pleasure, believe me,
Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning Shortage of Nurses in California

STATE OF CALIFORNIA

Board of Nurse Examiners

Sacramento, California, September 9, 1942.

To the Editor.—We are enclosing a copy of the Resolution adopted by the Board of Nurse Examiners at its meeting, September 3rd, 1942, in connection with the emergency regulations for the registering of out-of-state nurses.

Sincerely,

BOARD OF NURSE EXAMINERS,
By Kathryn Cafferty, R.N.

(COPY)

DEPARTMENT OF PROFESSIONAL AND VOCATIONAL
STANDARDS, BOARD OF NURSE EXAMINERS

At a meeting of the Board of Nurse Examiners on September 4, 1942, the following resolution was adopted:

WHEREAS, The state of National War Emergency is creating a serious shortage of nursing personnel in the United States of America and which has resulted in an acute problem in California, and,

WHEREAS, The present situation in California is erroneously attributed to the standards set by the Nursing Practice Act, and,

WHEREAS, It is the desire of the Board of Nurse Examiners to be helpful and to do all within their power to meet the nursing problems of the emergency; be it

Resolved, That the Board of Nurse Examiners does adopt, for the emergency, the following policy:

Out-of-state nurses who do not meet the total requirement for registration in California, but who are graduates of an accredited school in another state and who hold current registration in another state, shall be admitted to examination in California providing they comply with the preliminary requirements of the Board of Nurse Examiners; be it further

Resolved, That the applications of out-of-state nurses, graduates of accredited schools of nursing in another state and not registered in that state, will continue to be evaluated by the Board of Nurse Examiners, as previously, on an individual and professional basis; be it further

Resolved, That this policy has been established as an emergency measure and these rulings are not to be construed as precedents to be followed after the war.

BOARD OF NURSE EXAMINERS.

Concerning Article on Malpractice Insurance by Louis J. Regan, M. D.

The fourth article in a series appearing in the Editorial Comment department of C. and W. M., will appear in the November issue. G.H.K.

Concerning Relief to American Prisoners in Japan (COPY)

To the Editor.—Will you kindly publish the following item in the next issue of your JOURNAL, and oblige.

Sincerely yours,

(Signed) JOHN F. MARTIN.

The following resolution, as formulated by the Military Members in Service Committee of the Commonwealth Club of California, and approved by its Board of Governors, was adopted by the San Francisco Bay Chapter of the Military Order of the World War at its recent meeting. Major General Paul B. Malone, Commander of the local Chapter, states that this resolution is a laudable presentation of a humanitarian intention of those who belong to such organizations as the Commonwealth Club to do all they can to aid the men and women who are fighting and dying for our protection, as members of the armed forces of our Army and Navy, on the battle fronts in the present Global War.

The resolution is the result of a meeting of the Military Members In Service Committee, to which the local Chapter of the Military Order of the World War was invited to attend at the St. Francis Hotel on July 28, 1942. At this meeting, Colonel Warren J. Clear, U. S. Army, Retired, who was a member of General MacArthur's Staff in the Philippines, rendered a remarkable address, entitled: "Relief For the Victims of Bataan."

WHEREAS, The plight of the American soldiers made prisoners of war in the Philippine Archipelago is such as to arouse the deepest sympathy and concern of the American people; and

WHEREAS, These men have been ravaged by bacillary dysentery; amoebic dysentery, beriberi, scurvy, and other diseases induced by lack of food and conditions of tropical warfare; and

WHEREAS, Their physical condition since capture must have continued to deteriorate because of lack of medicines, vitamins, and foods essential to occidental well-being; and

WHEREAS, No alleviation of their plight can be effected through any humanitarian appeal to the Japanese military authorities who are obligated under international conventions only to provide these men with the ration of the common Japanese soldier; and

WHEREAS, It is represented to us by competent testimony that food and medical shipments to these men may be safely forwarded through the American Red Cross and the Imperial Japanese Red Cross, with reasonable assurance of delivery to our prisoners; be it

Resolved, That the Commonwealth Club of California, acting through its Board of Governors on the recommendation of its Military Members in Service Committee, records its unqualified support to the movement organized to gather and forward supplies for our American soldiers and nurses who are now war prisoners; and be it

Resolved, That the Commonwealth Club not cease to urge upon the appropriate agencies of the Government and the American Red Cross the vital needs of these men and the urgent necessity of continuing relief shipments to the officers, nurses, and the men who so gallantly upheld the highest traditions of the armed forces of the United States and through whose heroic sacrifices we continue to enjoy a freedom and privileges in sharp contrast to their present desperate situation.

CAPTAIN JOHN F. MARTIN, M.R.C.
*Adjutant, San Francisco Bay Chapter,
Military Order of the World War.*

Concerning Basic Science Law for California

Mayo Clinic

Rochester, Minnesota

Dear Doctor Kress:

I greatly enjoyed reading the proof of the editorials

concerning legislative activities in California. It seems to me you have stated the subject in a very clear and logical manner and it should act as a valuable guide and stimulus to legislative activity on the part of California physicians. I certainly wish you well in your efforts to pass a Basic Science law. We, in Minnesota, who have gone through the mill, can now afford to sit back and look on. If you wish any testimonials from Minnesota as to how the bill has affected the best interests of the public, we will be glad to make statements to that effect. It has greatly simplified the methods of controlling quackery and isms. It is too bad you did not have such a bill passed in California long ago.

With best wishes, I am,

Sincerely yours,

WILLIAM F. BRAASCH.

Concerning Tuberculosis Supplement in July Issue of C. & W. M.

CALIFORNIA TUBERCULOSIS ASSOCIATION

Dear Dr. Kress:

I have just had an opportunity to look over the Tuberculosis Supplement which was published in the July issue of CALIFORNIA AND WESTERN MEDICINE. I think you and your editorial staff did an unusually fine job in preparing the material for publication. I am sure that those of us who are interested in tuberculosis will find many opportunities to refer to these articles now that they are recorded in permanent form.

It is the hope of the Association that many of the articles will prove of interest to general practitioners and others over the State who are not limiting their work to diseases of the chest.

On behalf of the State Association, I wish to thank you for your splendid coöperation and express the hope that this pleasant relationship may be continued in future years.

45 Second Street.

Sincerely yours,

(Signed) REGINALD H. SMART, *President.*

We owe it to ourselves to try to understand what is going on in the world and to prepare to carry on into the future the greatest values which the human race has found.—*Dr. Ada L. Comstock.*

NOMINEES FOR CALIFORNIA LEGISLATURE (Additions)

A tentative list (almost complete at time of the writing), of candidates nominated for California State Senate and Assembly appeared on pages 224-225 of the September issue. Additional names, since received, are given below.

California Senate

District Number	Name of Candidate and Residence	Party Nomination
24	George Hatfield, Merced. Rancher.....	(Republican)
24	Elmer B. Maze, 804 20th St., Merced. Rancher.....	(Democrat)

California Assembly

District Number	Name of Candidate and Residence	Party Nomination
10	Harold F. Sawallisch, Richmond. Incumbent.....	(Democrat)
17	Edward J. Carey, 4506 San Pablo, Emeryville. Insurance Broker.....	(Democrat and Republican)
28	R. W. Sturtevant, 2296 3rd St., Palo Alto.....	(Democrat)
28	Raup Miller, 2237 El Camino Real, Palo Alto. Insurance.....	(Republican)
30	Ralph M. Brown, 915 Carolyn Ave., Modesto. Attorney.....	(Democrat)
30	Stewart W. Conover, Turlock. Rancher.....	(Republican)
36	C. L. Guthrie, 627 Mill St., Porterville. Cattleman.....	(Democrat and Republican)
46	Glenn M. Anderson, 582 N. Hawthorne Blvd., Hawthorne. Mayor.....	(Democrat)
46	Chas. E. VanDer Oef, 551 Acacia Ave., Hawthorne.....	(Republican)
73	Frank C. Russell, Crestline. Incumbent.....	(Democrat)
73	Douglas P. Armstrong, Redlands. Rancher and Lawyer.....	(Republican)
74	Clyde A. Watson, 273 N. Harwood St., Orange. Incumbent.....	(Republican)
74	Ross H. Boyd, 1429 N. Bristol, Santa Ana.....	(Democrat)

deal of "back-tracking" and "side-tracking" inquiry in the territory between these two points established the probable route taken and brought to light a large number of known or strongly suspected animal contacts. The owners of 24 of these chose to have them destroyed, and the remainder were placed under quarantine.

Within a period of 5 months and 7 days, 21 animal contacts of the original rabid dog developed rabies. Of this number, 20 were dogs and one was a cat. Only four had rabies of the "furious" type, 17 being cases of "dumb" rabies. The incubation periods varied from 10 days to 5 months and 7 days, but all except one of the cases developed within 8 weeks or less, and all except four within 30 days or less. There were no known human contacts of the original case, but there were 11 human contacts of 6 of the secondary cases.

MAP OF PROBABLE ROUTE

The accompanying map gives a graphic picture of the probable main route traveled by the original rabid dog and of the consequences of his menacing journey, and may perhaps convey a sketchy idea of the amount and type of work necessary to trace the contacts and bring them under control. No map, however, can show the fact that many people still doubt the existence of such a disease as rabies and consequently will do nothing to help an investigator trace possible rabies contacts, and the additional fact that many others, wanting to keep their pets and hoping that they may escape infection even though bitten by a rabid animal, conceal the knowledge of these having been contacts, with the mistaken idea that if this knowledge were divulged the pets would be destroyed. These two facts, together with the "stray dog" situation, make the rabies control problem unusually difficult with us here in Los Angeles County.

Los Angeles County Health Department,
808 North Spring Street.

California Heart Association Announces Annual Lecture Courses.—The guest speaker will be T. Duckett Jones, M.D., of Harvard University Medical School. One of his major topics will be an unpublished report on a ten-year study of one thousand cases of rheumatic fever. Additional information may be secured through the San Francisco, Los Angeles and San Diego County Medical Societies.

The *San Francisco Heart Association* meetings will be held on November 5th, 6th and 7th, in connection with University of California and Stanford Hospitals.

The *Los Angeles Heart Association* will present its sessions on November 12th and 13th, in connection with the Los Angeles County General Hospital and the Los Angeles County Medical Association.

On November 10th, the *Heart Committee of the San Diego County Medical Society* will give a dinner meeting

cal Society with its question of whether the practice of medicine is a "trade" within the meaning of the Sherman Act.

The medical societies were convicted in May, 1941, of conspiracy to restrain trade in the District of Columbia, in violation of the Sherman Act, through activities allegedly aimed at Group Health Association, Inc., a cooperative organization designed to procure low-cost medical treatment for its members, mostly Government employees. Among other acts, the societies were alleged to have sought to foster a boycott of physicians connected with the cooperative.

The A.M.A. was fined \$2500 and the local society \$1500

Twenty individuals indicted with the organizations were acquitted by the jury.—*San Francisco Chronicle*, October 13.

Armed Forces to Total of 7,500,000 Men in 1943: Medical Personnel Will be Needed.—Washington, D. C. dispatches (INS), dated October 14, contained the information quoted below. With seven physicians needed for every 1,000 soldiers (7,000 physicians for every one million men) a total of 50,000 physicians must be attached to the Medical Corps of the armed forces, if needs of the proposed army of 7,500,000 are to be adequately protected:

In urging the draft of 18 and 19 year old youths, Secretary of War Stimson told the House military affairs committee that the United States is planning for an Army of 7,500,000 men in 1943, including an air force of 2,200,000, and General George C. Marshall declared before the Senate committee that the chief aim is to keep the war outside the western hemisphere by creating a strong "offensive striking force."

Older Men "Burden"

General Marshall declared that the older draftees were "a burden to the Army" and that he wants to send them back home.

Both the secretary and the general said the Army of 7,500,000 is planned for the end of 1943 and that youths of the 18 and 19 year groups will be needed to bring this about.

Asserting that he wanted to eliminate the confusion which has been created by "unapproved estimates not from the Army itself," the secretary of war said:

"We are planning to build up in 1943:

"1. The largest air force, with sustaining units, which production and transportation will permit, and our estimate is that it will be composed of 2,200,000 men. If there are any changes it will be revised upward.

"2. We are planning to train and equip large ground units that can be transported overseas, and we expect them to be composed of 3,300,000 men. This figure includes units now already overseas.

"3. We estimate that there also will be 1,000,000 men in training or engaged in training others in the service of supply.

"4. There will be an additional 1,000,000 men actually in the service of supply.

"There are now in the Army 4,250,000 men, already inducted.

"So, adding together those we now have plus those we intend to have, we will have a force by the end of 1943 of 7,500,000 men."

And in the end, through the long ages of our quest for light, it will be found that truth is still mightier than the sword. Because out of all the welter of human carnage and human sorrow and human weal the one great indestructible thing that will always live on is a sound idea.—*Gen. Douglas MacArthur*.

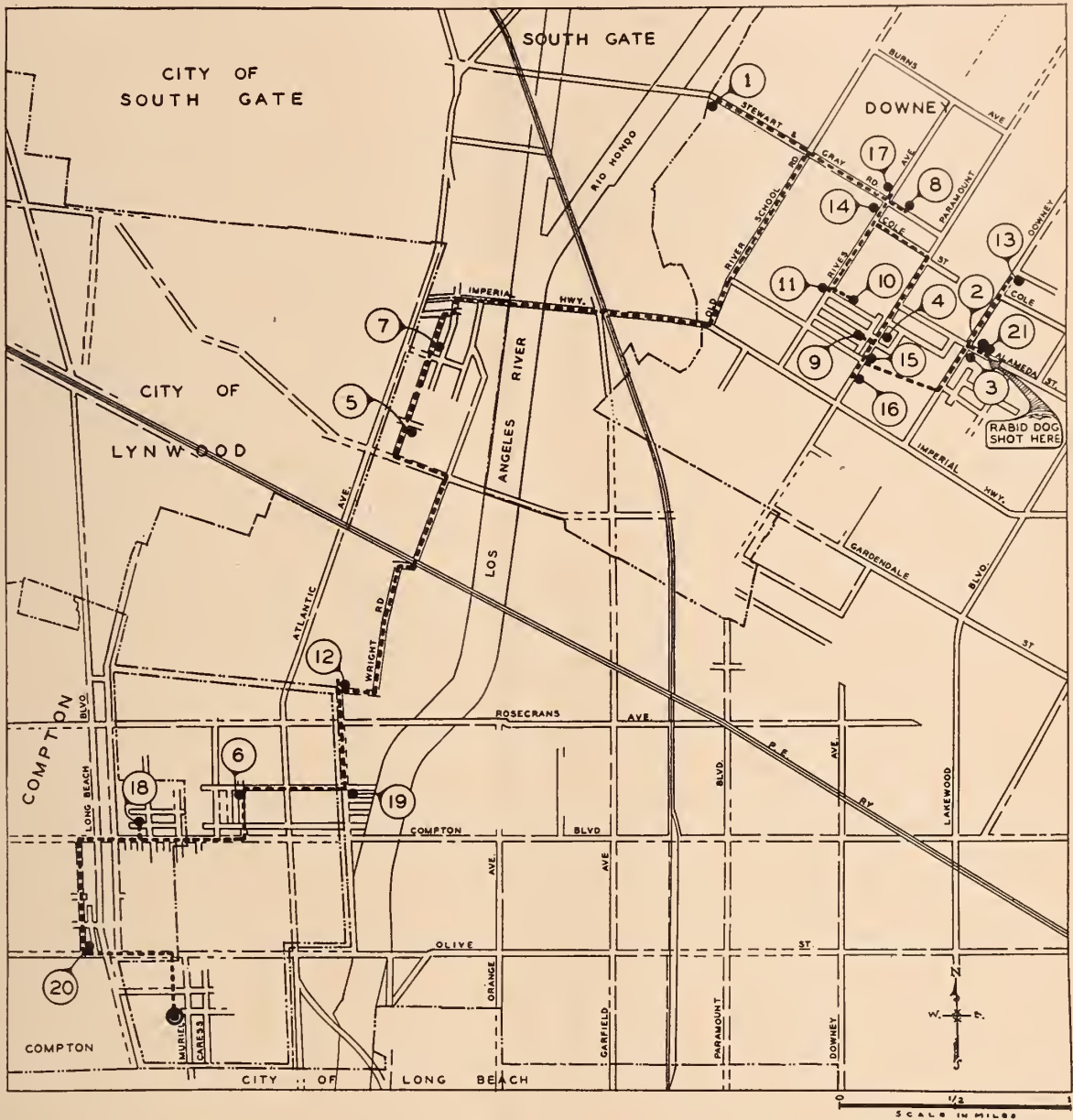
Always examine the exact spot of which the patient complains.—*E. P. Hanes*.

The three P's of Spinal Cord Tumor: "Pain, paresthesia and paresis."

Snap diagnoses are like gold plating—shiny but shallow.

U. S. Court Will Review A.M.A. Case.—Washington, Oct. 12. (AP.)—The Supreme Court agreed today to review the anti-trust law conviction of the American Medical Association and the District of Columbia Medi-

SEE HOW RABIES SPREADS!



● HOME OF A RABID DOG

—— ROUTE TRAVELED BY THIS RABID DOG

①, ②, ETC. - LOCATIONS OF SECONDARY CASES OF RABIES.
THE NUMBER IN THE CIRCLE SHOWS THE ORDER OF
THE CASE IN POINT OF TIME OF ONSET

Explanatory Note Concerning Chart "See How Rabies Spreads"

Diagram to illustrate the area in which 20 dogs were bitten by one rabid dog.

The probable route (as shown on the above chart, of a street area in the city of Los Angeles), taken by the original rabid dog during a period of about 48 hours amounted to at least 12 miles, and included some fairly short sections known to have been traveled twice. Of the 21 rabid animals, victims of the original rabid dog, and the locations of whose homes of owners are shown on the chart, seven dogs were bitten on May 14, twelve on May 15, and two on the morning of May 16.

Generally speaking, although there were several exceptions, the bites were more frequent and more severe as time went on during the forty-eight hours, and as the "furious" symptoms of the original rabid dog's disease became more marked. The first four dogs bitten by the rabid animal, to show symptoms, occurred in animals that were among the latest and most severely bitten.

The correlation between severity of bite and shortness of incubation period was striking throughout the group of secondary cases (twenty dogs in all, bitten by the figure twenty and the word Compton), is shown in the original rabid dog (on Muriel Street almost opposite the original rabid animal). The home of the owner of the left lower corner.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 10, October, 1917

EXCERPTS FROM EDITORIAL NOTES

The Maintenance of Indemnity Defense Fund.—The initial assessment for the organization of the Indemnity Defense Fund [of the California Medical Association] was fixed at \$30.00, one-half to be paid in cash upon subscription, and the balance by note due one year thereafter. In fairness to those who joined the Fund promptly, it was necessary to fix a limit upon this method of payment, and, therefore, December 31, 1917, was settled upon as the last maturity date for notes covering the deferred payment. In other words, a member joining the Fund at any time subsequent to January 1, 1917, paid \$15.00 in cash and the maturity date of the note given by him was December 31, 1917, no matter at what date he came in, and, of course, this rule obtains for all members joining at any time up to December 31, 1917.

Commencing January 1, 1918, the Council has decided that the full initial assessment of \$30.00 be paid in cash. This ruling is, of course, dictated by the interests of those who have been prompt in becoming Contributing Members.

Despite what has been said and written upon the subject, we are still in receipt of many inquiries on the subject of assessments, and particularly as to whether or not these assessments will be levied regularly each year. This is not the intention, nor the design of the Fund. . . .

Nostrums and Quackery.—Under the heading of Notices there appears in this issue a list of the A.M.A. publications concerning nostrums and quackery. The list includes much spicy reading, and much that is disgraceful to any modern, civilized country. The mere repetition of it all is nauseous, yet the public, including the doctors, must know what is going on, and without publication, this cannot be. Therefore the publication. No other reason would justify it. And still in spite of the publication of these and similar exposés, the newspapers of California reek of nostrums, many of them of proved worthlessness, and smell to high heaven with the stench of abortionists, and beauty doctors (save the name!), and quacks of the most brazen sort. If the people really want such muck, are they entitled to get it? And again, do they want it? Would it pay to have a California newspaper free from such advertising? Would it be good business for commercial bodies to purge the press at least in part of such advertisements? Would there be any possible effect on strangers and prospective tourists and investors? We think there would. Think it over, and decide if such be the case, why the physicians of each town and city should not take the lead in purifying the public press of the state of nostrum, quack, charlatan and plain abortionist advertising.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Basis for Medical Examination in the Army." [October, 1917.]—Perhaps it were well at this time, when the decision of rejection or acceptance of drafted men rests in the hands of civilian

(Continued in Back Advertising Section, page 24)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

News

"Dr. Juno N. Garner, 36-year-old osteopathic physician and surgeon of 3958 W. 111th St., Hawthorne, was held in the County Jail yesterday on a charge of performing an illegal operation. Dr. Garner denied any illegality. Bail was set at \$1500 and arraignment scheduled for 10 a.m. today in Division 4, Municipal Court." (Los Angeles Times, August 11, 1942.)

"The California Business Women's Council was on record today as advocating immediate use of women physicians and surgeons in the United States armed forces. . . ." (U.P. Dispatch dated Riverside, August 4, printed San Francisco News, August 4, 1942.)

"Governor Olson today named Dr. F. O. Butler, medical superintendent of the Sonoma State Home, to serve as acting director of the State Department of Institutions, pending selection of a permanent director. . . . Butler succeeds Dr. Aaron J. Rosanoff, whose resignation was effective August 1. . . ." (San Francisco Examiner, August 7, 1942.)

"Dr. A. M. Lovaas' appeal to the superior court from a conviction in the Santa Ana justice court on a charge of violation of the state medical practice act was lost this week, when Judge Kenneth E. Morrison upheld the decision of the lower court. Dr. Lovaas was tried before a jury in Justice Howard Cameron's court, and fined \$250 on November 28, 1941, after he was found guilty on two of three counts brought against him. His appeal has been pending since. In upholding the lower court, Dr. Lovaas is now required to pay the fine or carry an appeal to Appellate Court, which he has indicated he will not do. Basis for the prosecution of Dr. Lovaas was an alleged treatment of E. W. Leuenberger, to whose tonsils Dr. Lovaas allegedly applied an electrode. Judge Morrison held that ' . . . electrical treatments constitute the practice of medicine and surgery.' He went on to explain that California law provides that chiropractic deals with placements of vertebrae for relief of pressure on nerves. Principal ground for appeal by Dr. Lovaas, who was represented by Attorneys Harry Westover of Santa Ana and S. B. Kaufman of Anaheim, was that electrode treatment of this nature was taught in the chiropractic school he attended. There was no contest on the point that the electrode treatment was applied, Dr. Lovaas contending his right to practice such a system." (Santa Ana Independent, May 28, 1942.) The records show Dr. A. M. Lovaas is licensed by the Chiropractic Board.

"Speeders may come in for trouble before local tire-rationing boards, according to reports from State headquarters. Rationing boards' denials of tire purchase certificates to speeding or reckless drivers are authorized in a new OPA ruling covering the five western states.

(Continued in Back Advertising Section, page 32)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.



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- *The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.*

The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, *Acta Paediatrica*, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., *New York State Journal of Medicine*, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*



A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, coconut oil, corn oil, and cod liver oil concentrate.

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● MANY physicians recommend the water in conjunction with the treatment of stomach, liver and kidney trouble.

ADAMS MINERAL SPRINGS is one of these seven known iron and manganese bi-carbonate springs in the world, and the only one in Western America.

It is not a cure-all, but it overcomes acid excesses in the body, and is a very mild but wonderfully effective eliminator. The bowels function without spasm, the kidney output is greatly increased, and there is marked drainage of bile from the gall bladder and liver.

There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

We will be pleased to cooperate in any way whatever, and samples of water are yours for the asking.

A Natural Mineral Water SHOWING MAIN CONSTITUENTS

By PROF. SYDNEY A. TIBBETTS, Berkeley

MANGANESE	1.3 parts per million
IRON	12.5 parts per million
CALCIUM	173.3 parts per million
MAGNESIA	339.3 parts per million
SODIUM	365.0 parts per million
SILICA	93.0 parts per million
CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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OF SAN FRANCISCO

California's Oldest National Bank

Member Federal Deposit Insurance Corporation

ONE MONTGOMERY STREET

BOOK REVIEWS

(Continued from Front Advertising Section, Page 18)

and semi-private institutions, on the other hand, have shown a loss of 5 per cent in beds, this loss being almost entirely in the strictly private institutions.

For the purposes of classification, the institutions have been divided into the following categories: *public* (federal, state, county, city, and city-county); *private* (supported only by fees of patients); *semi-private* (supported partly by private contributions and endowments, partly by fees of patients, and, in some cases, partly by public funds).

Such classification shows that there are now available for tuberculosis in continental United States 74 federal institutions (9,380 beds); 406 state, county, city, and city-county institutions (71,877 beds); 49 private institutions (2,717 beds), and 180 semi-private institutions (13,752 beds).

Synopsis of Ano-Rectal Diseases. By Louis J. Hirschman, M.D., F.A.C.S., Ex-Vice President, A.M.A.; Ex-Chairman, Section on Gastroenterology and Proctology, A.M.A.; Ex-President American Proctologic Society; Chairman, American Board of Proctology, Inc.; Professor of Proctology, Wayne University; Fellow (Honorary) Royal Society of Medicine; Extra-Mural Lecturer on Proctology, Postgraduate School, University of Michigan; Proctologist, Harper, Charles Godwin Jennings, and Woman's Hospitals; Consulting Proctologist, Detroit City Receiving, Evangelical Deaconess, Wayne County Hospitals, Children's Hospital of Michigan, Detroit Tuberculosis Sanitarium, Detroit. C. V. Mosby Company, 1942.

This synopsis contains 295 pages, with numerous illustrations; and covers the general field of ano-rectal diseases. The author states that the book is meant as a guide to the general practitioner. Dr. Hirschman has spent many years in his specialty; his teachings are sound. The present edition is up-to-date and a safe guide to those who will read it.

PHILIP J. DICK.

Liver Extract Squibb

- LOW IN TOTAL SOLIDS
- EXCEPTIONALLY CLEAR

IN PERNICIOUS ANEMIA, Liver Extract in adequate dosage will produce a prompt reticulocyte response and hematologic recovery. Once dosage requirements have been established and the blood picture returned to normal, administration may be reduced to two- or three-week intervals.

Concentrated Liver Extract Squibb (15 units injectable per cc.) offers the advantages of being low in total solids, and exceptionally clear and light colored. Its high concentration affords low dosage volume and may save the patient considerable discomfort. Furthermore, cost of maintenance is appreciably less than with effective doses of liver principle given orally. It is available in 3x1-cc. vial packages and in 5-cc. and 10-cc. vials.

Liver Extract Squibb is a sterile, aqueous solution, obtained from edible liver. Both the regular and concentrated potencies are standardized on the basis of the hematopoietic response in pernicious anemia as defined by the U.S.P. Anti-Anemia Preparations Advisory Board. This Board has ruled that at present a strength greater than 15 units per cubic centimeter will not be assigned to a preparation because of the possibility of loss, during the concentration process, of unknown factors of value in the treatment of patients with pernicious anemia.*

Solution Liver Extract Squibb (3.3 units injectable per cc.) is especially prepared. It is *not* made by diluting Concentrated Liver Extract. It is available in 10-cc. vials.

* N. N. R. 1941, p. 328.

For literature address Professional Service Department, 745 Fifth Ave., New York, N. Y.

E·R·SQUIBB & SONS

Manufacturing Chemists to the Medical Profession Since 1858



TWO POTENCIES

3.3 units (injectable) per cc.
15 units (injectable) per cc.
Preservative—0.5 per cent phenol

HAVE YOU PATIENTS

**With Any of
These Conditions?**

Hernia?

**Enteroptosis
with
Symptoms?**

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Lumbo-sacral
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tive
Conditions?**

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Conditions?**

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Send for Free Booklet
offered below

● When you prescribe a Spencer Support you are assured it will meet your specific requirements, as well as the patient's figure-needs, *because* it will be individually designed, cut and made for the one patient who is to wear it. In addition, it will improve the general health of the patient by means of *posture correction*.

Spencers are non-elastic, light in weight, flexible, perfectly comfortable and easily laundered. They are exceptionally durable and are guaranteed NEVER to lose their shape. (A support that stretches or yields under strain loses its effectiveness.)

● For service at your office, hospital or patient's home look in telephone book under "Spencer Corsetiere" or write direct to us.

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Abdominal, Back and Breast Supports

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Please send me booklet, "How Spencer Supports Aid the Doctor's Treatment."



M.D.

Address P-5



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MEDICINE—One Month Course in Electrocardiography and Heart Disease starting the first of every month, except December.

FRACTURES & TRAUMATIC SURGERY—Informal Course available every week.

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GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

TEACHING FACULTY * ATTENDING STAFF OF
COOK COUNTY HOSPITAL

Address: Registrar, 427 South Honore Street,
Chicago, Illinois

TWENTY-FIVE YEARS AGO

(Continued from Text Page 282)

doctors, to shed some light on what the physical requirements of examination of recruits for service in the army really are.

It is much to be desired that the Exemption Board exercise the same care in the selection from the drafted material as would the recruiting officer in the service. Noticeable physical defects eliminating the man as a candidate are readily discernible. Amongst these might be classed:

Impediment in speech; strabismus, convergent or divergent; loss of eye; total loss of either thumb; entire loss of any finger except the little finger; prominent flexion of one or more fingers; adherent or united fingers; lack of freedom in movement of joints; deviation from prescribed standard of physical proportions; scars of hideous disfiguring proportions; defective teeth; loss of ear; a loss of material of the ear, causing disfigurement; purulent otitis or diseases of the mastoid cells; a deviation of the septum of the nose or any contraction of the nasal orifice interfering with respiration; a lack of legal, moral or intellectual qualifications. . . .

From an Article on "Tumors of the Kidney," by Stanley Stillman, M.D., San Francisco.—When I was asked by the Chairman of the Urological Section to contribute a paper on Tumors of the Kidney at this Symposium, based as much as possible on personal experience, I cheerfully accepted the invitation, honestly believing that I had seen a considerable number of cases; but as has been often the case with myself, and perhaps with some others too, when it came to facts, I could find in my per-

(Continued on Page 25)

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MANAGER

PARK SANITARIUM 1500 PAGE ST.
SAN FRANCISCO.

TWENTY-FIVE YEARS AGO

(Continued from Page 24)

sonal records of twenty-five years only 7 cases of renal tumors, excluding pyo- and hydronephrosis and polycystic kidney. Of my immediate associates, one has seen 3 cases, another 2, and another 1; so that in our experience tumors of the kidney are much more infrequent than we thought. In 1885, S. W. Gross collected all the reported cases that had been operated upon up to that time and the number was only 47, of which 33 were diagnosed sarcoma and 14 carcinoma. . . .

From an Article on "Treatment of Drug and Alcoholic Addictions," by A. C. Matthews, M. D., Napa State Hospital.—That the subject of the care and treatment of the unfortunate alcoholic and drug habitué has been a neglected as well as puzzling one, I think every one who is somewhat familiar with the facts will admit. The delay in taking action with a view of doing something for these individuals is due to many factors difficult of solution. The problems are sociologic, moral, and medical, and many failures have resulted because sociologic problems have been dealt with medically or medical problems dealt with morally. Years ago, the addiction was almost universally regarded as a mere moral perversion—a bad habit entered into and continued because of moral degeneracy. . . .

From an Article on "Practical X-Ray Work for the General Practitioner," by Albert Soiland, M. D., Professor Roentgenology, College of Physicians and Surgeons, University of Southern California.—As the number of men who are limiting their work to roentgenology is so large, and with practically every hospital equipped

(Continued on Page 26)



The McKenzie School of Individual Instruction

A non-profit, co-educational resident and day school conducted in a homelike environment on a large orchard estate at Los Altos, in the beautiful Santa Clara Valley of Northern California.

The McKenzie School is the only one West of the Mississippi equipped to educate privately children with impaired hearing.

Direction is by Lilla B. McKenzie, graduate of Central Institute for the Deaf, St. Louis; Studied Science of Speech, Acoustics and related subjects under Louis C. Elson, E. K. Klare, B. Cutter and Charles Kidder, Boston. School is staffed especially to develop each child according to his own abilities.

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THE POTTENGER SANATORIUM AND CLINIC, Monrovia, California

TWENTY-FIVE YEARS AGO

(Continued from Page 25)

with apparatus, there seems today to be little need for the general practitioner concerning himself with the trouble and expense of buying an outfit. For those, however, who are so situated as to be deprived of the services of a good roentgen laboratory, and who are desirous of doing their own work, it is well to spend some time to learn the fundamentals, and then ascertain just what to buy to suit their individual needs. There are other men, however, who live in communities where there are a number of excellent x-ray institutions, and who could get such service both efficient and economical, yet spend a great deal of money for apparatus of their own just because Dr. So-and-So across the street has just installed the biggest x-ray machine west of New York. . . .

From an Article on "The Use of the Aspirator for Removing Pus, Blood, Exudate, Transudate, and Bowel Contents During Surgical Operation," by Edmund Butler, M.D., San Francisco, Calif.—The removal of blood and mucus from the pharynx during operations in the nose and throat, by means of some suction apparatus, is an accepted procedure. The use of the same apparatus by the general surgeon has been neglected. This method of removing blood, pus, exudate, transudate, cyst contents, and bowel contents, is very practical and efficient. . . .

From an Article on "The Malaria Problem in the Rice Fields," by Stanley B. Freeborn, University of California.—The advent and phenomenal growth of the rice industry in California has introduced a serious public health problem. The growing of rice demands that the

entire acreage under cultivation be flooded from approximately June 1st to October 15th to a depth of about five inches with water, stagnant or in a gentle current.

Unlike the malarial mosquitoes of other rice-growing districts, the Anophelines of the Sacramento Valley find their optimum breeding grounds in these fields flooded for rice culture. As a result, mosquitoes, and consequently malarial cases have increased in direct proportion to the growth of the industry. . . .

From an Article on "The Late Correction of Mal-United Fractures of the Extremities," by P. S. Campiche, M.D., San Francisco.—The treatment of fractures has received so much attention in the last few years, and the progress made in this branch of surgery has been so great, that it seems as though a bad result should now be a thing of the past; and yet, for reasons to be stated below, it appears that mal-union still occurs in a large number of cases. It goes without saying that the best anatomical and functional result should always be our aim, but this ideal is not attained at all times, and the fact remains that even nowadays the primary treatment of many fractures often results in disaster. . . .

From an Article on "Medical Military Matters in California." [October, 1917]—To the Editor:—The situation in California is progressing in regard to its response to the call for medical officers in the army. Up to the first of September, 533 surgeons, or 9.4 per cent of the medical population of the State, had been recommended for appointment in the Medical Officers' Reserve Corps. According to the calculation, however, California's quota for the 20,000 medical officers needed would be 800, so

(Continued on Page 28)

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WHEN sailormen come bigger, huskier, more battle-worthy, one likely reason for the improvement will be the kind of rations with which they started life.

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Baker's is rich in essential protein (40% more than breast milk)—plus complementary gelatin, an adjusted fat, two added sugars, extra vitamins and iron . . . all in highly tolerable form, for infants from birth through bottle feeding.

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beginning day of disability.

Send for applications, Doctor, to
400 First National Bank Building . . . Omaha, Nebraska

TWENTY-FIVE YEARS AGO

(Continued from Page 26)

that it still has 260 odd men to supply. These must come from those who are less than 55 years old, have no imperative obligation (such as the charge of an isolated community or necessary work in hospital or medical school or in sanitation), who are able to arrange for the care of their dependents or who have an income apart from their professional income, which will support their dependents. . . .

Very truly,

(Signed) HARRY M. SHERMAN, M. D.,
Sept. 13, 1917. . . . San Francisco.

From an Article on "Exemption of Medical Students and Interns." [October, 1917.]—Interns and students who shall not have been called by a local board may enlist in the Medical Enlisted Reserve Corps, such enlistment entitling them to discharge from draft if thereafter called. . . .

An intern who is enlisted in the Medical Enlisted Reserve Corps hereunder will be called into active service under his enlistment, if his services are needed, at the end of one year of internship. Applications for commission in the Medical Reserve Corps, from interns who, at the expiration of one year's internship, are called for duty as members of the Medical Enlisted Reserve Corps, or from interns whose year of internship is about to expire, will receive proper consideration.

A medical student (undergraduate) who is enlisted in the Medical Enlisted Reserve Corps hereunder will be called into active service under his enlistment, if his services are needed, on failing to pass from one class to another, or on failing to graduate. . . .

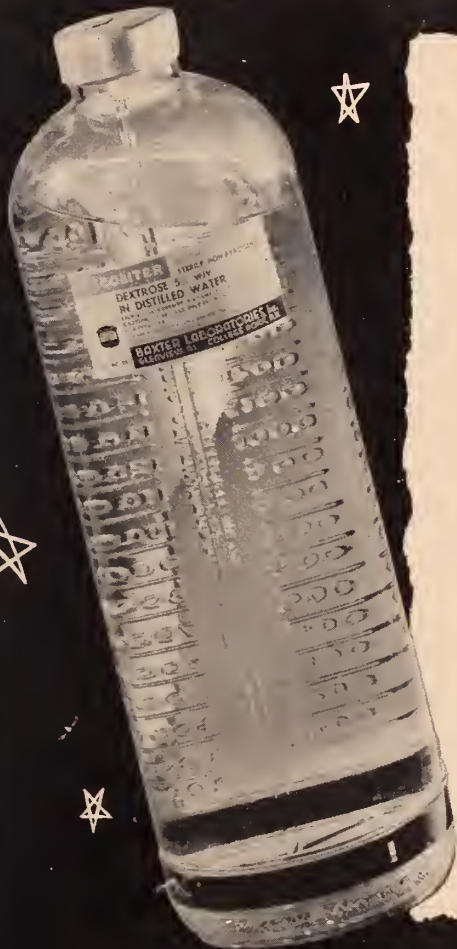
(Continued on Page 32)

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is of immeasurable advantage to the hospital. Its essential simplicity and uncomplicated technique increase the safety of infusion.

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*J. M. Lewis, Journal of Pediatrics, May, 1939

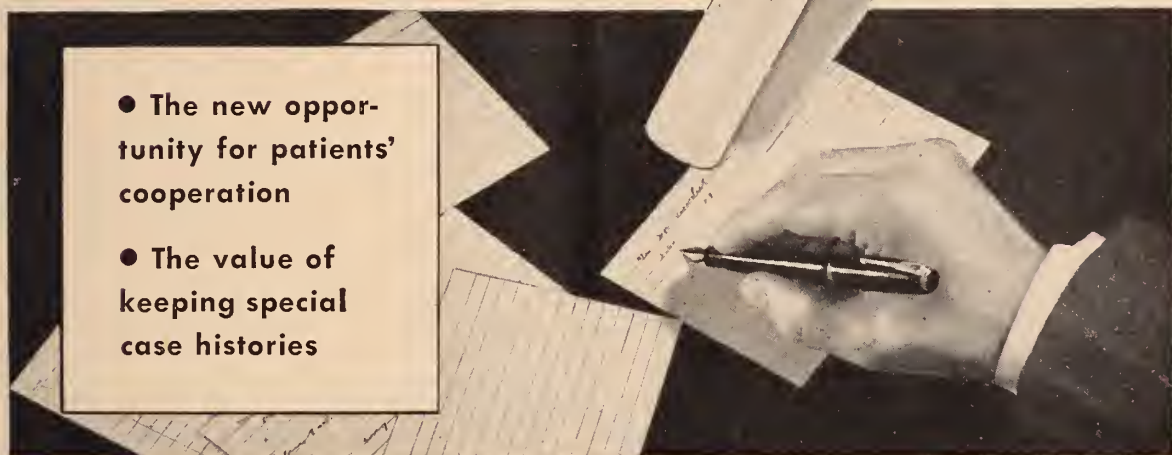
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THE relationship of nicotine intake to certain sub-clinical symptoms is of interest to the physician.

Time was when clinical observation in such cases was difficult. Patients were reluctant to fall in with limitations on smoking.

Now your recommendation of slow-burning Camels* is a simple step towards securing this cooperation. Millions have found an added "pleasure factor" in Camel's special mildness and unusually fine taste.

In anticipation of more accurate data when adjusting smoking hygiene, we suggest that you keep a separate file of these case histories. This may lead to interesting conclusions.

★

**The Military Surgeon*, Vol. 89, No. 1, p. 5, July, 1941
J.A.M.A., 93:1110—October 12, 1929

Brückner, H.—*Die Biochemie des Tabaks*, 1936

★

"THE CIGARETTE, THE SOLDIER, AND THE PHYSICIAN," *The Military Surgeon*, July, 1941. Reprint available. Write Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.

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RHEUMATISM, ARTHRITIS, KIDNEY AND BLADDER DISORDERS

Hydrotherapy Combined With a Warm Dry Climate

For particulars write

LEE RICHARDSON, RICHARDSON SPRINGS, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Page 28)

From "State Board of Health—Bureau of Venereal Diseases." [October, 1917.]—The State will coöperate with the army and navy in reducing venereal diseases in the men stationed in California to a minimum. To do this it will be necessary to prevent these diseases in the civil population near army and navy posts, and to extend the work as rapidly as possible throughout the State.

To carry on this work it was recommended to Governor Stephens, on August 13th, by the Military Welfare Commission that a Bureau of Venereal Diseases be established under the State Board of Health, and that \$60,000 be appropriated from war emergency funds for its support during the next two years. . . .

From "State Board of Medical Examiners."—Attention has been called to the alleged violation of certain Japanese who, we understand, are practicing medicine and surgery in this State without the formality of obtaining a license issued by this board, as provided in Statutes of 1913, Chapter 354, effective August 10, 1913; Statutes of 1915, Chapter 105, effective August 8, 1915, and Statutes of 1917, Chapter 81, effective July 27, 1917. . . .

Examination Questions of State Board of
Medical Examiners:

Anatomy and Histology

W. R. Molony, M. D.

9 to 11 a.m., July 10, 1917

(For Physician and Surgeon and 2,000 Hours Applicants)

1. Give origin of all of the muscles which pass across

the hip joint, that is, those that have the joint between the origin and insertion.

2. Describe the attachment of the ribs to the vertebral column.
3. Describe the olfactory system; mucous membrane, olfactory nerves, olfactory bulb and cerebral connections.
4. Describe fully the spinal accessory nerve; phrenic nerve.
5. Describe fully the location, formation and distribution of the deep and superficial cardiac plexes.
6. Describe in detail each variety of epithelium found in the urinary tract beginning at the glomerulus and ending at the meatus urinarius.
7. Discuss the falmar fascis.
8. Discuss the arch of the foot; how formed and how maintained.
9. Locate five important groups of lymph glands and give drainage area.
10. Discuss the mesentery. Name subdivisions; locate each; describe the largest.
11. Discuss the clavicle—connection and relations.
12. Discuss erectile tissue and tell all places found in the body.

Answer ten questions only.

General Diagnosis

H. E. Alderson, M. D.

10 a.m. to 12 m., July 12, 1917

(For 1,000 Hours Drugless Applicants Only)

1. Describe and discuss four stigmata of hereditary syphilis.
2. Discuss the significance of a heavily-coated tongue.
3. Discuss the significance of diarrhea.

(Continued on Page 34)

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Highly Active BACTERIOSTATIC AGENT

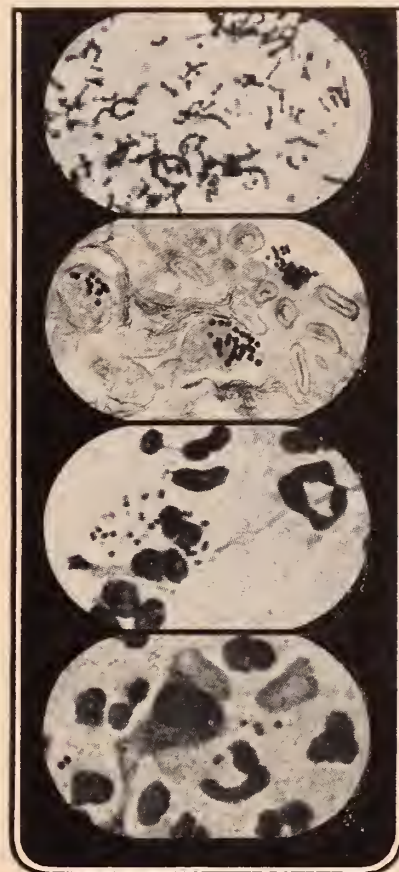
Sulfathiazole exerts a prompt bacteriostatic effect upon a number of pathogenic organisms. A pronounced action is observed on the following:

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Remarkable clinical results have been consistently obtained in infectious conditions caused by these organisms. Complications which are commonly encountered in pneumonia, gonorrhea or meningitis are greatly reduced in frequency and severity.

The dosage should be adjusted to the nature of the disease, as well as to the age and condition of the patient. Write for dosage chart and booklet on Sulfathiazole-Winthrop.

Sulfathiazole-Winthrop is supplied in tablets of 0.5 Gm. (7.72 grains), bottles of 50, 100 and 500; also (primarily for children) in tablets of 0.25 Gm. (3.86 grains), bottles of 50, 100 and 500. Sterile powder is available in bottles of 5 Gm., ¼ lb. and 1 lb.



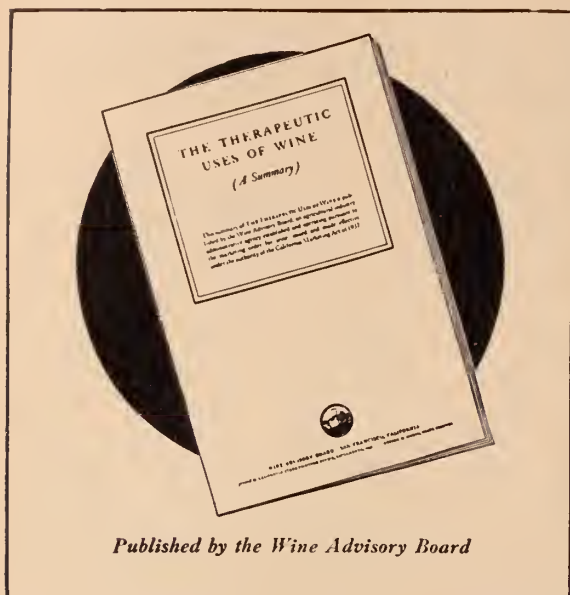
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The contents include sections on wine as a food, and the actions of wine on the gastro-intestinal system, the cardio-vascular system, the genito-urinary system, the nervous system and the muscles, and the respiratory system. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and convalescent are also discussed. The value of wine as a vehicle for medication is dealt with, and an important section on the contraindications to the use of wine is included. An extensive bibliography is presented for those who may wish to pursue the subject further.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

Members of the medical profession are invited to write for this monograph. Requests should be made to the Wine Advisory Board, 85 Second Street, San Francisco.



May We Suggest CALSO WATER for the Urologists

Indications

For all Genito-urinary infections, particularly the irritated bladder of Prostatitis

Pre- and Postoperative Treatment

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Indicated in combinations with Sulfa therapy

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Palatable

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CALSO WATER is not a laxative.

TWENTY-FIVE YEARS AGO

(Continued from Page 32)

4. Discuss the diagnosis of insolation (sunstroke).
5. Discuss the differential diagnosis of mucous patches.
6. Discuss the diagnosis of shock.
7. Discuss the diagnosis of iliocolitis.
8. A girl 15 years of age is pale, has dysmenorrhea, frequent dyspnoea and occasional vertigo. Discuss the probable causes.
9. Discuss the diagnosis of high blood pressure in a man 40 years of age.
10. Discuss the differential diagnosis of variola in its earliest phases.
11. A man has a hard noninflammatory tumor over the upper sternum. Discuss the possible diagnoses.
12. Describe and discuss four varieties of abdominal hernia.

Answer ten questions only.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 282)

Effective July 1, boards can demand an affidavit from any tire applicant certifying that he has not driven more than forty miles an hour except for emergencies. . . . Rationing regulations were amended today to require that vehicles operated by physicians, surgeons, farm veterinarians and ministers, be used 'exclusively for professional services' in order to be eligible for tires and tubes. The new regulations announced by regional office of price administration headquarters make licensed chiropractors and osteopaths eligible under the same conditions applying to doctors of medicine. . . ." (Monrovia Journal, July 9, 1942.)

(Continued on Page 36)

★

★



When depression accompanies more fundamental pathology

In many patients, depression may occur as an accompaniment of some more fundamental pathology, either organic or psychogenic. In such cases, the physician should bear in mind that, while Benzedrine Sulfate will not affect the underlying condition, its stimulatory effects may help to alleviate the concomitant depression which so often interferes with the management of the case.



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Benzedrine Sulfate is primarily useful in depressions characterized by apathy and psychomotor retardation, but is contraindicated in patients manifesting anxiety, hyperexcitability, or restlessness.

The use of Benzedrine Sulfate by normals should not be permitted; it should always be administered under the careful supervision of a physician; and depressive psychopathic cases should be institutionalized.

In treating depressed patients with Benzedrine Sulfate, the physician should bear in mind that any drug which produces pleasant or euphoric effects may prove to be habit forming—especially in unstable or neurotic individuals.

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MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

"The Supreme Court of California has denied the application for rehearing in the case of the People versus Dr. H. O. Cleland. This action brings to a close the cases on file against Dr. Cleland, county physician and superintendent of the County Farm. The status of the cases yet on file is based on the assumption that Dr. Cleland is a county official and not an employee. This assumption the District Court of Appeals denied, handing down the decision that the county physician is an employee, not an official. The law of the state differentiates in the responsibility between the two offices. An appeal from the decision of the Appellate Court was taken in the matter and a hearing asked by the Supreme Court. This hearing was denied. The indictments against Dr. Cleland as county physician and superintendent of the County Farm were brought by the Grand Jury of 1941-42. Two charges were heard before juries in the Superior Court of this county and in both cases a not guilty verdict was returned. The action of the Supreme Court automatically dismisses any cases in the indictments filed many months ago." (Ukiah Redwood Journal, August 6, 1942.)

"Dr. A. M. Tweedy (Tweedie), with offices at 3326 W. 54th St., pleaded guilty to a charge of 'assault by means and force likely to cause great bodily injury'—the alleged assault consisting of the administration of an anesthetic. According to Deputy District Attorney George Johnson, the anesthetic was given Mrs. Leona Tarleton, of 533 Seventh Street, Santa Monica, who died. Dr. Tweedy (Tweedie) asked for probation, hearing on

(Continued on Page 39)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

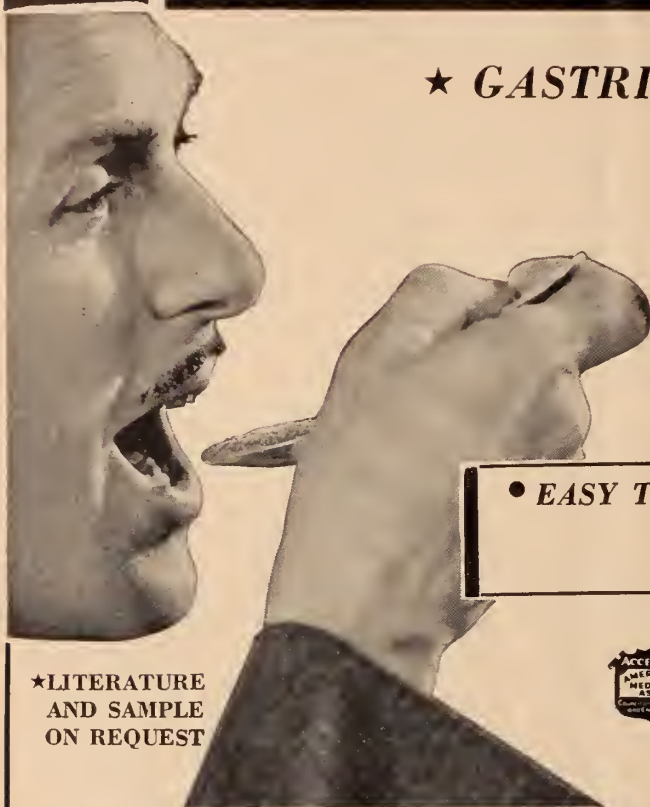
No initials
are set down
on prescriptions
for pharmaceuticals
more often . . .
none inspire
greater faith
in their merit
than . . .



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THE MODERN METHOD

A disinterested and highly informative report by Dr. Regine K. Stix appearing in the January 24, 1942, issue of the Journal of the American Medical Association, describes three studies of contraceptive clinics in different sections of the United States as made under the supervision of the Milbank Memorial Fund. The report shows that many women cannot or will not use the diaphragm and jelly method. In such cases, we suggest the use of the Servex Powder method. The Servex Combination Powder Set, packed in an attractive box, contains all four essentials of the powder technique, including diaphragm, powder, inserter and powder insufflator.

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A class "A" building affording every modern facility. Located 12 miles from Long Beach. Choice rooms from \$42.50 per week including medical service. Classification of patients according to type of illness. Beautiful quiet gardens: Insulin, Metrazol and Electro Therapy. For particulars address: Garden Grove Sanitarium, Garden Grove, Calif.

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Acousticon is accepted by the Council of Physical Therapy of the American Medical Association

BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

which was set by Superior Judge William R. McKay for Sept. 10." (Los Angeles Herald and Express, August 22, 1942.)

"The police today warned Modestans to be wary of a man posing as a specialist in treating foot ailments, who travels from house to house. The man was described by the police as a faker. He travels in a trailer. No detailed description was obtained." (Modesto Bee, August 22, 1942.)

"Because a doctor assertedly performed a wrong operation on her, Mrs. Tina Mundy, 24-year-old artist's model,

is \$7,249.72 richer. She received a check for that amount from attorneys for Dr. P. S. O'Reilly, Glendale physician, after Superior Judge Goodwin J. Knight refused to grant the doctor a new trial. Mrs. Mundy was awarded the money following a 28-day trial in which she contended her 'ability to bear children had been permanently impaired.' Through her attorney, Harry C. Mabry, she told the court her troubles with the doctor had resulted in a separation between herself and her husband, Jerry Mundy, an automobile mechanic." (Los Angeles Times, Sept. 5, 1942.)

"Police yesterday raided the office of Dr. Philip J. Murphy, 617 South Olive St., and arrested him on suspicion of performing an illegal operation. Dr. Murphy, the officers said, admitted he had performed abortions over a period of two years. A woman who was being prepared to undergo an operation was reported found in the doctor's office. Police took statements from two women employes but did not arrest them." (Los Angeles Daily News, September 3, 1942.)

"Dr. Paul Rumph, local physician, reported to police yesterday the theft of a service kit from his car, which was parked in front of St. Joseph Hospital, but which was found, later, by a Santa Ana resident, minus some of its contents. The kit, when taken, contained a stethoscope, several different medicines, blood pressure instruments, hypodermic needles, a prescription pad, and some narcotics. A Santa Ana rancher found the bag in the corner of his grove, and returned it to Dr. Rumph. Missing from the bag when the rancher found it were the hypo needles and the narcotics." (Orange News, August 24, 1942.) Comment: Evidently the narcotic addicts are again raiding unlocked automobiles of physicians and surgeons.

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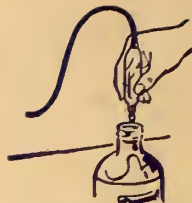
[‡]Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J., and Wigodsky, H. S.: *Aluminum Phosphate in the Therapy of Peptic Ulcer*, *Arch. Int. Med.* 67: 563-578 (March) 1941.

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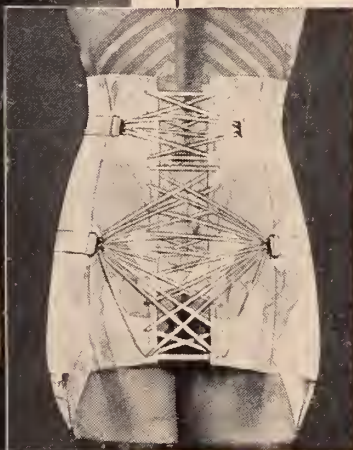
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1. Ivy, A. C.: J. A. M. A. 117:1151 (Oct. 4) 1941.

2. Lauda, E.: Cholangitis, in Piersol, G. M.: Cyclopedia of Medicine, F. A. Davis Co., 1940 vol. 4 p. 228.



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Riverside County Medical Society
President Pro-tem, Thomas Card, 3616 Main Street, Riverside.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Henry L. Saverien, 2626 L Street, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, John W. Cline, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Deon A. Crew, 748 Marsh Street, San Luis Obispo.
Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. A. Shufelt, 241 E. Santa Clara Street, San Jose.
Secretary Pro-tem, John Hunt Shepherd, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, M. D. McPherson, Vine and Church Streets, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Monday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Julius M. Kehoe, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, R. L. Zieber, 838 Fourth Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, Oakdale.
Secretary, Hoyt R. Gant, 401 Beatty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, O. T. Wood, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Charles S. Ambrose, 310 W. Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Leo A. Cronan, Davis.
Secretary, Austin M. Clark, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John A. Duncan, 725 4th Street, Marysville.
Secretary, Neal M. Loomis, 439 Center St., Yuba City.
Meeting, *Second Wednesday.*

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(Continued from Page 3)

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

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Members who contemplate presentation of scientific papers should promptly address the secretary of the proper section, as per addresses which follow. Correspondence concerning scientific exhibits, and medical and surgical films, should be addressed to the Chairman of the Committee on Scientific Work: George H. Kress, M. D., 450 Sutter, San Francisco.

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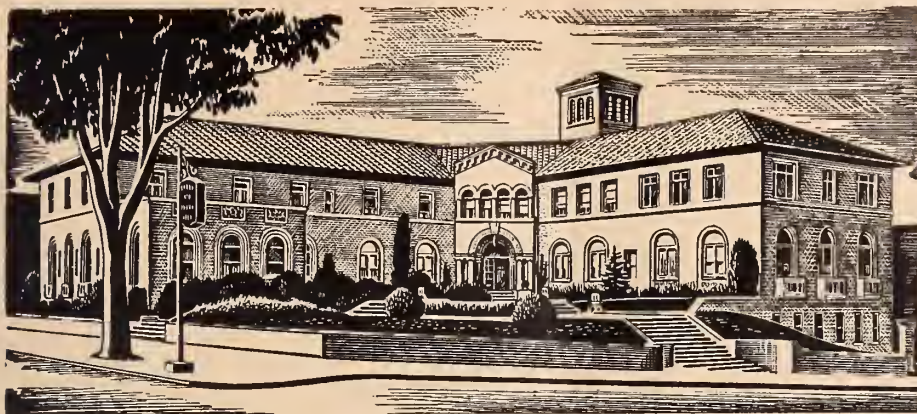
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Miscellaneous California Medical Organizations

Department of Public Health of the State of California San Francisco—603 Phelan Building, 760 Market Street, San Francisco; Underhill 8700. Sacramento—1020 N St., Phone 2-4711. Los Angeles—State Office Building, 217 West First Street, MAdison 1281. President, Elmer Belt, Los Angeles Director, Bertram P. Brown, 603 Phelan Building, 760 Market Street, San Francisco	Board of Medical Examiners of the State of California San Francisco, Rm. 214, 515 Van Ness Ave. Los Angeles, 906 State Building. Sacramento, Business and Professional Building, 1020 N Street. Secretary, C. B. Pinkham, Room 214, 515 Van Ness Avenue, San Francisco.	The Public Health League of California Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRespect 5711.
California Northern District Medical Society President—John H. White, Chico. Secretary—J. Homer Woolsey, Woodland Clinic, Woodland.	Southern California Medical Association President, Ray B. McCarty, 3116 Main Street, Riverside Secretary, Nelson Paul Anderson, 2007 Wilshire Blvd., Los Angeles.	Medical Schools of California University of California Medical School, Third and Parnassus, San Francisco. Francis S. Smyth, M.D., Dean. Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean. University of Southern California Medical School, 1100 N. Mission Road, Los Angeles. Seeley G. Mudd, M. D., Dean. College of Medical Evangelists, 312 North Boyle Avenue, Los Angeles. Walter E. Macpherson, M. D., President.



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BOOK REVIEWS

BOOKS RECEIVED

When Doctors Are Rationed. By Dwight Anderson, Director of Public Relations, Medical Society of the State of New York, and Margaret Baylous, Therapist, Charleston General Hospital, Charleston, West Virginia. Cloth. Pp. 225. Price \$2.00. New York City: Coward-McCann, Inc., 1942.

Doctors of the Mind. The Story of Psychiatry. By Marie Beynon Ray. Price \$3.00. Cloth. Pp. 325. Illustrated by Ruth Ray. Boston: Little, Brown and Company, 1942.

The Making of a Surgeon. By Ernest V. Smith, M.D., D.Sc., F.A.C.S. Price \$3.00. Cloth. Pp. 344. Illustrated. Fond Du Lac, Wisconsin: The Berndt Printing Company, 1942.

The Principles and Practice of Medicine. Originally written by Sir William Osler, Bart., M.D., F.R.C.P., F.R.S. By Henry A. Christian, A.M., M.D., LL.D., Hon. Sc.D. Hon. F.R.C.P. (Can.), F.A.C.P. Hersey Professor of the Theory and Practice of Physic, Emeritus, Harvard University; Physician in Chief, Emeritus, Peter Bent Brigham Hospital; Visiting Physician, Beth Israel Hospital, Boston. Fourteenth Semi-centennial (1892-1942) Edition. Leather. Pp. 1475. New York: D. Appleton-Century Company, Inc., 1942.

Changes in the Knee Joint at Various Ages. With particular reference to the nature and development of degenerative joint disease. By Granville A. Bennett, M.D., Associate Professor of Pathology, Harvard Medical School; Hans Waine, M.D., Research Fellow in

(Continued on Page 10)

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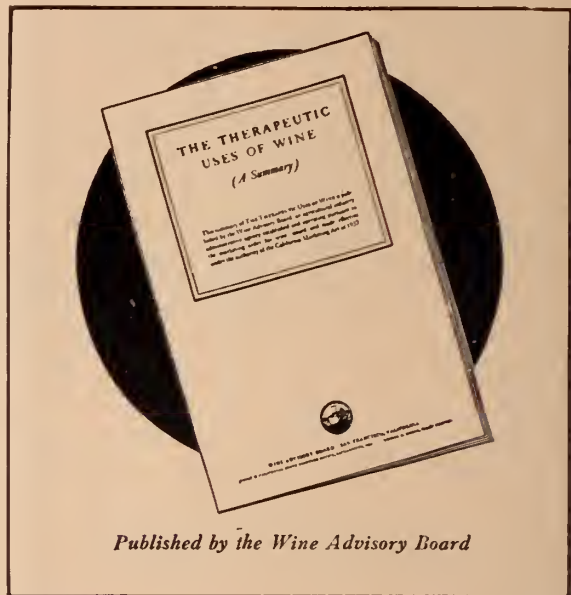
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This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

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(Continued from Page 7)

Medicine, Harvard Medical School; Graduate Assistant in Medicine, Massachusetts General Hospital and Walter Bauer, M. D., Associate Professor in Medicine, Harvard Medical School; Physician to the Massachusetts General Hospital; Director, Robert W. Lovett Memorial Foundation for the Study of Crippling Diseases, Price \$2.50. Cloth. Pp. 97, with illustrations. New York: The Commonwealth Fund, 1942.

Tables of Food Values. By Alice V. Bradley, M. S., Associate Professor of Nutrition and Health Education, State College, Santa Barbara, California. Completely revised and enlarged. Price \$3.50. Cloth. Pp. 224. Peoria, Illinois: The Manual Arts Press, 1942.

BOOK REVIEWS

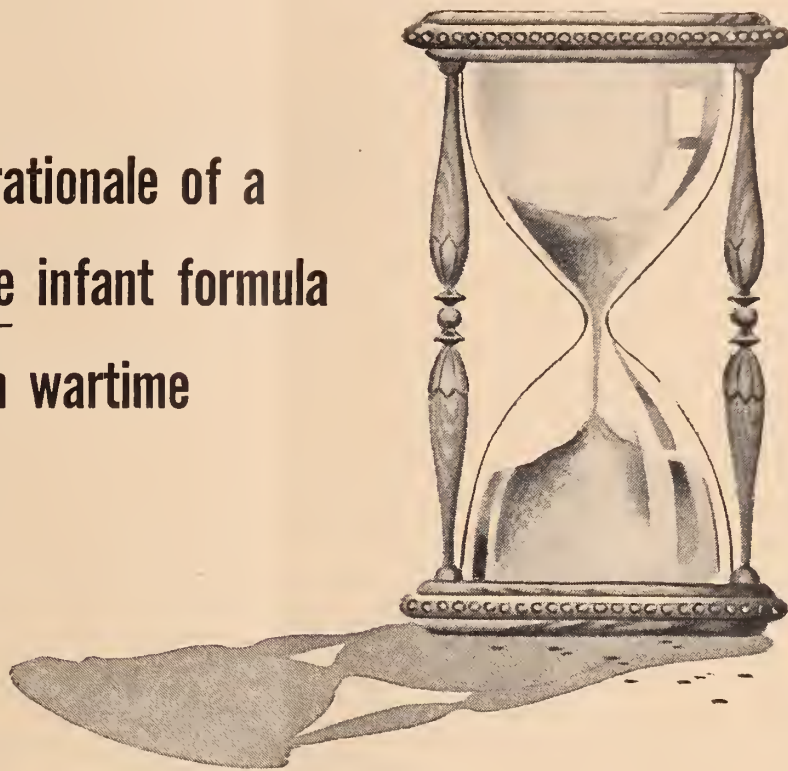
The Essentials of Emergency Treatment. By the Connecticut State Medical Journal. Paper. Price \$1.00. Cloth. Price \$2.00. Pp. 144. New Haven: The Whipples-Bullis Co., Inc., 1942.

In the current issue editorial comment is made concerning the above volume. For the information of readers, the titles of the sections of contents are listed below.

I Introduction	Samuel C. Harvey	1
II The Organization and Function of the Emergency Medical Service in Connecticut	William J. German and George M. Smith	3
III The Systemic Effect of Injury, Peripheral Circulatory Failure ("Shock")	Samuel C. Harvey	13
IV Crush, Blast and Anesthesia in War Emergencies	Gervase J. Connor	18
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(Continued on Page 14)

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This increase in birth rate has been accompanied by a reduction of the infant mortality rate to 47.0 per thousand live births in 1940, which was the lowest ever recorded for the birth registration area. However, the provisional infant death rate for 1941 is 46.2, which would seem to predict a further decline.

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* The Military Surgeon, Vol. 89, No. 1, p. 5, July, 1941

J. A. M. A., 93:1110—October 12, 1929

Brückner, H.—Die Biochemie des Tabaks, 1936

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"THE CIGARETTE, THE SOLDIER, AND THE PHYSICIAN," The Military Surgeon, July, 1941. Reprint available. Write Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.



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BOOK REVIEWS

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A Manual of Roentgen Diagnosis. By Kenneth S. Davis, M.S., M.D., Professor of Radiology, College of Medical Evangelists, Clinical Professor of Medicine (in Radiology), University of Southern California School of Medicine, Radiologist to St. Vincent's Hospital. Cloth. Price \$3.50. Pp. 160, with 279 illustrations. Los Angeles: Lithostat reproduction by Cossitt & Co., Inc. (Offices—Hobart Bldg., Mills Tower Bldg., San Francisco.) Master Photolith Copy by N. W. Sheldon, San Francisco, 1941.

Dr. Davis has assembled one of the most interesting and satisfactory teaching manuals in roentgenology that we have today. While designed for medical students, its concise and accurate presentation will also make it a valuable reference book for the general practitioner. The common diagnostic problems are well

(Continued on Page 16)



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BOOK REVIEWS

(Continued from Page 14)

illustrated with line drawings and film productions running continuously with the text, and these illustrations are exceptionally well chosen.

Throughout the book, Dr. Davis insists that accurate diagnosis depends on a complete history and thorough physical examination, and that these should precede any roentgenographic study. He emphasizes the need for correlation of the laboratory findings with the clinical picture. When roentgen findings are inconsistent with the clinical picture, he states that the examination must be repeated as often as is necessary to establish a diagnosis.

This emphasis on clinical study is especially important in view of the frequent custom of requesting x-ray first, and making a clinical examination later.

The instructor will find Dr. Davis' manual a well-balanced and satisfactory book in connection with lectures to medical students, while the general practitioner will find the manual a most helpful reference book in solving common diagnostic roentgenographic problems.

LYELL C. KINNEY.

Doctors of the Mind. The Story of Psychiatry. By Marie Beynon Ray. Price \$3.00. Cloth. 325 pp. Illustrated by Ruth Ray. Boston: Little, Brown and Company, 1942.

In the introduction the author states that the public (and who can blame it?), does not read medical journals, and the scientist does not speak the public's language. That is why she has endeavored in this book to act as an interpreter between them. The writing of this book, attempting to meet the demands of the scientist for technical accuracy and of the layman for a

(Continued on Page 17)

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MANAGER

BOOK REVIEWS

(Continued from Page 16)

straight-forward account of exciting events with plenty of human interest, drama, and color, was, you may imagine, highly acrobatic.

The author stated that she has endeavored to bring into dramatic relief the battles of the pioneers of psychiatry as they worked with infinite caution in the shadowy caverns of the human mind. She deals, for instance, with Mesmer and the hypnosis he developed; with Freud, who first gathered the threads of hypnosis and suggestion into the science of psychoanalysis; and, in our own day, with Sakel and his discovery of the insulin-shock treatment for schizophrenia. She tells of Wagner-Jauregg, who injected the deadly malaria germ into the insane in a desperate effort to burn out

their afflictions; of a clinic in Rome where electricity was thrown into the bodies of schizophrenics, and of many other tense and almost terrifying experiments.

The Making of a Surgeon. By V. Smith, M. D., D.Sc., F.A.C.S. Price \$3.00. Cloth. 334 pp. Illustrated. Fond Du Lac, Wisconsin: The Berndt Printing Company, 1942.

This volume is a personal sketch of the author's career in which he elaborates concerning his boyhood days and outlines his experiences, first as a small-town physician and then, later, his experiences as a specialist. The book would, no doubt, be of interest to his friends and members of his clientele.

Tables of Food Values. By Alice V. Bradley, M. S., Associate Professor of Nutrition and Health Education.

(Continued on Page 18)

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CALSO WATER is not a laxative.

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(Continued from Page 17)

State College, Santa Barbara, California. Completely revised and enlarged. Price \$3.50. Cloth. 224 pp. Peoria, Illinois: The Manual Arts Press, 1942.

Everyone engaged in nutrition work realizes the need of food tables which are authentic, inclusive, and practical. The essentials of an adequate diet in terms of specific types of food to be used daily to meet those recommendations are given in a simple outline. Charts, also, give all data needed for rapid, accurate, and complete calculating or the appraising of diets for all age-groups and activities.

The greatest change has been in the field of vitamins, which are given in *units* and *milligrams*; while the mineral values are shown in *shares* and in *grams*.

The author states that it has been her experience in nutrition work that a table giving the composition of average servings of food without the necessity of calculation is very valuable. These tables, showing the values of average servings, will be most helpful for such a purpose.

The Management of Fractures, Dislocations, and Sprains. By John Albert Key, B. S., M. D., St. Louis, Mo., Clinical Professor of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's and Jewish Hospitals; and H. Earle Conwell, M. D., F. A. C. S., Birmingham, Ala., Orthopaedic Surgeon to the Tennessee Coal, Iron and Railroad Company, and the Orthopaedic and Traumatic Services of the Employees' Hospital, and to the American Cast Iron Pipe Company; Chairman of the Committee on Fractures and Traumatic Surgery of the American Academy of Orthopaedic Surgeons. Member of the Fracture Committee of the American College of Surgeons. Associate Surgical Director of the Crippled Children's Hospital, Attending

(Continued in Back Advertising Section, Page 22)

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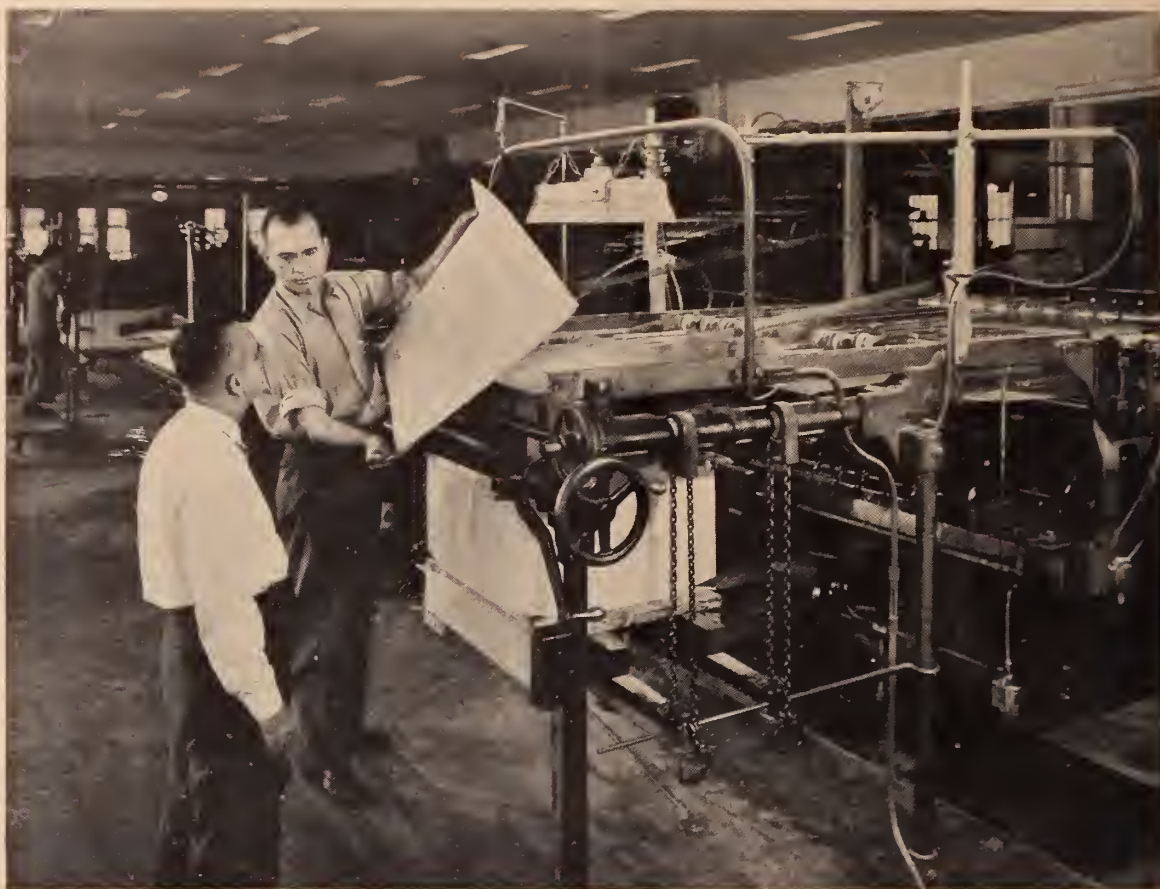
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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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California and Western Medicine

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F. Burton Jones Vallejo 1914
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Secretary and Editor ex officio

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Subscription prices, \$5 (\$6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

BASIC SCIENCE INITIATIVE DEFEATED: A CALAMITY FOR CALIFORNIA CITIZENS

Basic Science Initiative Was Not Approved by California Electorate.—Voters who went to the polls on November 3rd—through the ballots they cast—laid the foundation for many surprises. Not the least of these was the sad fate meted out to the Basic Science Initiative (Proposition No. 3), for which, in 9,356, out of a total of the State's 14,494 precincts, votes to the number of 1,002,352 were cast; a total of 385,444 votes having been deposited in favor of the Basic Science Act, with the greater total of 616,908 against it. In other words, Proposition No. 3, according to returns available at the time of this writing, went down to defeat by the massive number of 231,464 votes!*

* * *

How the California Counties Voted.—The Basic Science Initiative was overwhelmed in in nearly all sections of the State, the only counties having a majority of votes in favor of the law that would have made it mandatory for all healing-art practitioners to have had preliminary education of what may be said to be the equivalent of a full high school course and one year of college work, being listed below (with the favorable majority figures in parenthesis): Marin (61); San Benito (57); San Francisco (16,065); San Mateo (112).

* * *

In Retrospect.—That so desirable an addition to the statutes as the Basic Science Act should have been lost, with a majority of practically 500,000 or more votes cast against it—a measure that would have made for greater conservation of public health through supply of better trained practitioners of all kinds—is so surprising that it may be desirable to make further comment.

* * *

State Association's Record Above Reproach.—In relation to the California Medical Association, no apologies are made for sponsoring a law that would have given to the citizens of California a better healing-art service, with greater protection of health and life.

It is unfortunate that the drafting of statutes necessitates the use of legal phrasology that can be distorted by specious interests. In the recent campaign, some of the "Political Notices" against

* For a partial compilation of the vote on No. 3, by counties, see in this issue, on page 335.

the proposed Basic Science Law, and which, in display form, appeared in the newspapers, reeked with misstatements so sordid and far from the truth, that one might have been tempted to think that one was reading the text of a speech by a Bowery politician of former years.

* * *

Depths to Which a Smear Campaign Can Descend.—Take, for instance, the numerous quarter-page advertisements which carried a photograph of Ray Lyman Wilbur, Chancellor of Stanford University, with display text as follows:

"The man who would be medical Dictator of California. Amazing facts from authentic sources. Here are actual photographs from the book, 'The Medical Trust Unmasked,' by John L. Spivat."

And so on, ad nauseam.

Now, to Californians and, also to the medical profession and citizenry of the United States, Ray Lyman Wilbur, M. D., Chancellor of Stanford University, Chairman of the National Council on Medical Education and Hospitals, and former Secretary of Commerce of the United States, needs no defense. His record of achievement, from the time he began the practice of medicine in Palo Alto through all the years which followed, is an open book and is well known. That the healing-art groups who opposed the Basic Science Initiative should have found it necessary to descend to the low levels evidenced by the implications against Chancellor Wilbur and inserted in the above and other statements and publications, may be a partial explanation of why many voters may have been misled—so that, being in doubt, they cast their votes in the negative. (For the information of readers who may not have read the "Political Notice" referred to, the text comment appears in this issue in the News Department, on page 334.)

The appearance of these canards on the days immediately preceding the election, plus extensive mouthings of similar import over radio chains, created a situation which the Public Health League and those in charge of the campaign found difficult to meet. For, self-understandingly, organized medicine and dentistry, as represented by their State organizations and their friends, could not debase themselves by sponsoring similar statements, to spike previously presented canards and smears.

* * *

Policy for the Future.—Now as for the future—in regard to Basic Science objectives—CALIFORNIA AND WESTERN MEDICINE has no right to speak for the constituted C.M.A. authorities of the present or the days to come. The editor is tempted to believe, however, that no immediate effort will be made to resurrect the measure, and for the following reasons: Nonsectarian Doctors of Medicine, through their sixty-seven accredited schools of medicine, do not themselves need a law demanding that all licentiates shall

have given prior evidence of education equivalent to that comprehended in the work of a high school course and one year of college work. The medical schools comprising the Association of American Medical Colleges for years have demanded not only the above, but at least three instead of one year of college work. Standards of the accredited medical schools of the United States are not surpassed anywhere.

* * *

Cultist Groups Welcome to the Standards They Have Set for Themselves.—If the cultist groups of the healing-art are content to accept as sufficient preliminary education for their licentiates, a "reading, writing and arithmetic" standard, or—no matter how high-sounding their catalog announcements may be—an elastic interpretation of high school or equivalent education, that is their privilege. Such a policy will take them just as far as that kind of comparative training usually does in any walk of life. If victory for a limited educational standard is consolation for their ballot victory on November 3rd, sectarian groups are welcome to it, even though it be not for the good of the citizenry of California.

* * *

Full Reports Will be Made.—To carry on the clean campaign of the medical and dental professions, that was under the leadership of the California Public Health League, it was necessary for the Council of the California Medical Association to allocate funds up to sixty thousand dollars. That is a large sum of money, and in view of the action of the California electorate, it would now seem that it might have been put to better use. However, at the Coronado and Del Monte meetings, the House of Delegates of the California Medical Association gave definite instructions to submit a Basic Science Initiative to the voters of California. The campaign was fully on when the events of December 7, 1941, took place, transforming conditions into a wartime set-up—a contingency that was not foreseen by the C.M.A. House of Delegates.

At the next meeting of the Council, full report of the campaign will be made by the Association's Executive Secretary, who coöperated with the Public Health League, and in due course be presented to the House of Delegates at the annual session to be held in May, 1943.

* * *

Work Ahead is to Meet Other Responsibilities.—So that for the present, as the profession takes up consideration of more immediate responsibilities concerned with military, industrial and civilian practice, it may be permissible for us all, in relation to Proposition No. 3, to breathe for it the prayer,

*Requiescat in Pace.**

* A list of references to articles in CALIFORNIA AND WESTERN MEDICINE, on Basic Science and Qualifying Certificate laws appeared in the issue of August, 1941, on page 104. A brief historical outline was given in the same number on page 56.

HOW SHALL DOCTORS OF MEDICINE BE RATIONED?

Readjustments in Medical Practice are in the Air.—Since the Pearl Harbor attack on December 7, 1941, it is becoming increasingly apparent, as the months go by, that before the present World War is concluded, medical practice as it existed up to two or three years ago will receive shocks, of number and nature, sufficient to bring about many readjustments; not only during the duration, but also in the post-duration period. The cause for this phenomenon is probably found in the transfer—by the end of year 1942—of about one out of every three Doctors of Medicine, from the domain of private, into military practice.

* * *

Some Statistics Related to Military Medicine.—In our consideration of the medical rationing that is now going on, some pre-war statistics may aid in showing the trends of the changing relationships. Referring to our own State, the *California Medical-Economic Survey*—published by the California Medical Association in 1937—in Table Appendix G-8, on page 172, gave 625 persons as the population per practitioner for the entire State—the figure becoming 1,507 persons per physician when only “Counties less than 50 per cent Non-Farm” were tabulated. Again, in Volume 28 of *Medical Care for the American People*, on page 5, it is stated, “In 1929 there was one physician to every 571 persons in California.”

Let us turn now to news dispatches as of the date of the present writing, which shed light on the needs of medical personnel for the Armed Forces—to which wartime industrial production, as well as civilian needs, necessarily must be secondary. The press item refers to more than 6,000,000 men being in military service before December 31, 1942.* Dispatch follows:

6,000,000 Due in Army, Navy at Year's End

Washington, Nov. 6.—(INS.)—Developments indicated today that the United States would have more than 6,000,000 men under arms and probably 1,000,000 soldiers overseas by the end of this year.

Secretary of War Stimson revealed that the Army would have more than 4,500,000 men in service before 1943 and Secretary of the Navy Knox has disclosed that the U. S. naval strength will exceed 1,300,000 by the end of this year.

1,000,000 in Navy

General George C. Marshall, Army chief of staff, said that 800,000 American soldiers already were stationed overseas.

Asked if the Army would meet its goal of 4,500,000 men before 1943, Stimson said, “We will go considerably beyond that figure.”

Knox said there would be 1,000,000 men in the Navy, 200,000 in the Marine Corps and 100,000 in the Coast Guard by the end of this year. Knox's disclosure, coupled with Stimson's announcement, would place more than 6,000,000 men under arms by January 1.

Troops Girdle Globe

Already American troops are stationed around the face of the globe. Besides a large contingent in northern

Ireland, the Army officially has troops in Australia, Alaska, the Solomons, New Caledonia, Iceland and the Middle East. . . .—*San Francisco Call-Bulletin*, November 6.

* * *

Supply Source for Military Personnel.—The totals of licensed physicians in the United States, as compiled from figures in the record cases of the American Medical Association, gave 180,000 as the approximate number of living Doctors of Medicine. Of this number, about 159,000 physicians returned the A.M.A. questionnaires sent out by the national organization in 1940. While about one-half of these, or 80,000 doctors, stated they were willing to serve with the armed forces, there were only about 62,000 physicians who were between the ages of 21 and 45; and it is from this last named pool that the great majority of medical officers is secured.

The age period group which stops at age 45, includes a considerable number of medical men who are physically unfit for combat divisions; and others who, temporarily at least, have been classed as otherwise essential—because of positions held by them in wartime industrial plants, hospitals, or medical schools, or in communities which have been so depleted of resident physicians that those who remain must be at the service of twice, thrice or even a larger proportion of the population than prevailed before December 7, 1941.

With 7.5 medical men needed for every 1,000 soldiers, it is evident that within the next twelve months about 50,000 Doctors of Medicine, nearly all under the age of 45, will be in active service with the armed forces!

It follows that the removal of such a massive number of younger physicians from civilian practice must necessarily throw increased work upon doctors who remain at home. The situation is further complicated by the fact that many medical men in civilian practice, who have responsibilities in the care of employees in wartime industrial plants are practically on a semi-military basis, since the maintenance of health of citizens in wartime industries is likewise construed to have right-of-way over the needs of citizens in nonessential work, or in private life.

* * *

Medical Profession Approves the Objectives.

—Now, with all these needs and their relative importance and priorities, the profession of medicine is in full accord. Physicians, better than other citizens, know how necessary it is that there shall be at hand, always, wherever our American armed forces are stationed—let it not be forgotten, that on over-seas continents, already more than 800,000 soldiers have been placed—a pool of skilled surgeons who will be available for any contingencies that may arise. Not so to provide, would be destructive of morale not only for soldiers and sailors who are at the front, but also to their relatives and friends at home. And morale, at times, may take on the power of bullets or

* On November 10th, a Washington dispatch disclosed that “the fighting forces will number about 9,700,000 men by the end of 1943.”

other armed weapons.

* * *

War Manpower Commission has Studied these Problems.—All these matters, and a host of others of even more confusing nature, have been carefully studied by the War Manpower Commission, through the Procurement and Assignment Service for Physicians, on which Frank H. Lahey, M. D., of Boston, and present past-president of the A.M.A. is chairman, and which is represented in the Ninth Corps Area by Karl L. Schaupp, M. D., of San Francisco, now president-elect of the C.M.A.; and in California by Harold A. Fletcher, M. D., of San Francisco, as chairman for the northern section of the State and Edward M. Pallette, M. D., of Los Angeles, as chairman for southern division, this last area covering the fourteen counties south of the San Bernardino base line. These representatives of the medical profession have given unstintingly of themselves in service to our Country, and to the profession of which they are honored members. In times such as the present, they cannot, nor are they expected to find satisfactory or easy solutions for all problems coming under their jurisdiction. They can only hope that their decisions will measure up to good standards of human achievement.

* * *

On Administrative and Professional Medicine.—All who have had much actual experience in large administrative endeavors know how easy it is for complications to arise when rules that must be carried through by agents far from the source of pronouncement, are broken. Especially, under war conditions, regulations must be carried out in impersonal manner and universally applied, even though hardships and awkward or unfortunate situations occasionally arise through adherence to such a course. That explains why some of the conditions are not rectified.

* * *

Concerning Some Suggestions.—Thus, for instance, it has been pointed out that in many military camps located in California, and in other commonwealths, there are stations where the number of physicians so placed are in excessive number, with a minimum of professional work to occupy their time. It has been proposed that if physicians who are assigned to stations where there is seemingly an excess of medical men, and all of whom have received their initial military training, it might be of real aid in lessening the strain in many communities, if a limited number of such physicians could receive furloughs of several months duration—and renewable according to conditions—that would permit them to return to private practice where needs exist, but to be available for military duties on 12 or 24 hours' notice—just as are railroad engineers, policemen, and citizens in certain walks of life.

In line with the above also, it has been suggested that the Surgeon General might authorize the appointment of a larger number of civilians as administrative officers in the Medical Corps, thus relieving medical men from what is in one sense, only partly medical work, and that of a not over-enticing nature.

These comments have been made because the items considered, have been and are topics of conversation among physicians. The confusion now existing in the minds of many Doctors of Medicine, concerning further needs for military personnel in the medical branches of the armed forces may explain in part why some physicians in civilian practice, who are of proper age and physically fit, are somewhat slow in volunteering their services.

However, as should be the case, the issues will be decided by those in authority, and according to their best judgment. It is gratifying to all members of the medical profession to know that the constituted representatives of the Government have shown every willingness to work in close coöperation and harmony with organized medicine. And to physicians, both in and out of the Armed Services, it should be heartening that, by and large, the medical profession has made most generous effort to meet the obligations its members owe to our Country.

ON VARIOUS TOPICS

Medical Literature for Colleagues in Military Service
C.M.A. is Planning to Hold an Annual Session in May, 1943

Leases of Medical Officers: New Federal Law Gives Relief to Physicians in Military Service

Tributes to the Medical Profession by Newspaper Editors

Medical Journals on the Pacific Coast: Calling Attention to an Error

"Essentials of Emergency Treatment": An Excellent Brochure by Connecticut State Medical Journal

Medical Literature for Colleagues in Military Service.—The needs of military colleagues for medical literature were discussed in the first editorial in the September issue of CALIFORNIA AND WESTERN MEDICINE, on page 169; and again in the October number, where further comment was made on pages 230 and 250. On the same topic, the Letters department of the current issue presents two letters: one from Honolulu, Hawaii, and the other from Luke Field, Arizona.* The writers of the two communications emphasize the reasons why medical literature should be supplied to colleagues who are stationed in California camps of the Armed Forces.

By way of progress report, in regard to the

* See page 337.

plan of collecting medical journals as outlined in the discussions referred to, it is necessary to state that the three medical libraries of the State (University of California, Stanford and Los Angeles) report that up to present date, only meagre acquisitions have been received—so small in amount, indeed, as to be almost nil!

That a response should be so faint, is probably due to the busy lives now being led by physicians who remain in civilian practice. It surely cannot be affirmed that doctors who yet remain at home are indifferent to the needs and contentment of fellow physicians, who, in taking up the rigors of military training and duties, have voluntarily torn themselves away from the conveniences of practice in communities where all is yet at peace.

The obligations which those of us who remain behind owe to our fellows who have detached themselves from pleasant surroundings, in desire to serve our Country, are of such fundamental nature that continued reference may be made in the *OFFICIAL JOURNAL*, on the importance of meeting part of our debt to them, by furnishing to hospital stations in California, medical books and journals that may be of reference or other use.

To repeat: what is requested of physicians in civilian practice will require only small effort: namely, (1) to instruct office secretaries to collect from the shelves, and pack all medical journals or books not needed for home or office use; and (2) to deposit at or send such publications to one of the three medical libraries;* (or, if more convenient, to ship them collect, via Railway Express Agency to: C.M.A. Postgraduate Committee, Room 2004, 450 Sutter Street, San Francisco).

The State Committee will carry on from there. Your coöperation will be deeply appreciated.

C.M.A. is Planning to Hold an Annual Session in May, 1943.—Recurrently the question is put—"Is the California Medical Association planning to hold an annual session next year?", and the answer has been—"Yes, the Council has so decided, and an annual session will be held—unless military complications intervene—probably in May, 1943, at Del Monte." This decision is based on action taken at the close of the present year's annual session, and reaffirmed at the last Council meeting (see *CALIFORNIA AND WESTERN MEDICINE*, October, 1942, Item 21 of Council minutes, on page 248).

This brief notice is given to again call the attention of members to the plans under way, and to express the hope that they will consult with the proper section and other program officers, as noted in the outline which appeared in the October issue of *CALIFORNIA AND WESTERN MEDICINE*, on page 228.

Necessarily, the meeting will not be so largely

attended as in former years—owing to transportation difficulties and the large number of colleagues in military service—but the medical economic problems to be considered, and the new medical and surgical work to be publicized, will be as important or more so, in all probability, than many subjects that have received earnest discussions in recent peace-time years. Members and Section Officers are requested to feel free to make suggestions for the program. Military and Industrial Medicine will naturally receive special attention.

Leases of Medical Offices: New Federal Law Gives Relief to Physicians in Military Service.—Recently several letters have been received from members who were on the eve of induction into military service, regarding their legal responsibilities in the matter of office leases. Because of the importance of the subject, attention is called to two items appearing in this issue, in which the topics are discussed: the one, an excerpt from the *Jour. A.M.A.*, in its issue of October 17, 1942, on page 539; the other, a copy of an opinion by Legal Counsel Peart, which has place in the Letters department, on page 338.

Officers of County Societies may wish to call the items to the attention of members.

Of collateral interest to the above may be mentioned other articles, such as those on malpractice defense and financial obligations of colleagues in military service (see May *CALIFORNIA AND WESTERN MEDICINE*, on pages 316 and 330; and October, on page 275). Physicians who are contemplating entrance into military service and who have overlooked these discussions will find it advisable to scan them.

Tributes to the Medical Profession by Newspaper Editors of California.—Elsewhere, editorial comment appears concerning the vote on the Basic Science law, and reference is made to the low level to which some of the opposition's advertising announcements descended. Fortunately, partisanship that indulges in such activities reflects only upon its makers and sponsors.

Refreshing, in contrast, are the editorial paragraphs and other notices which, during recent months, have spontaneously appeared in newspapers throughout California, concerning the efficient service being rendered by Doctors of Medicine who are attached to the Armed Forces, and also to those who remain behind to carry on their duties in industrial and civilian practice. To offset the nauseating stuff which appeared in the recent quarter page newspaper political notices concerning Chancellor Wilbur of Stanford University—who was one of the three signers of the argument in favor of a Basic Science law—may we commend to those readers who may not have done so, perusal of the newspaper excerpts in which tribute is paid to the medical profession, and

* For library addresses, see item on page 337.

which have appeared in recent issues of CALIFORNIA AND WESTERN MEDICINE (see July issue, on pages 108-110; and in October number, on pages 269-270).^{*} The newspaper editors who so expressed themselves, and who are representatives of different sections of California, are truer interpreters of the place which Doctors of Medicine occupy in the community life of California, than are the purveyors of smear campaigns.

Medical Journals on the Pacific Coast: Calling Attention to an Error.—The *Western Journal of Surgery, Obstetrics and Gynecology*, in its issue of August, 1942, on page 430, gave editorial comment concerning the *Medical Sentinel*, an Oregon publication founded in 1895, the following being an excerpt from the editorial to which reference is made:

"The interesting fact is that the *Western Journal of Surgery* was originated in the embers, still glowing briskly, of the old *Medical Sentinel*. The *Medical Sentinel*, briefly, was founded in August, 1895, by Dr. Henry Waldo Coe, a pioneer spirit in the Northwest, both in business and in industrial affairs and in medical journalism. The early *Medical Sentinel* was a one-man affair. It had a lusty finger in every important pie in the medical affairs of the Northwest, yet it was the instrument of one man and used in some instances ruthlessly to represent very restricted professional interests. It represented some of the finest and some of the crudest aspects of early medicine in the West. It must be recalled that the growth and development of California followed by many years that of the Northwest and the annals therefore of medical history in the Northwest as recorded in the "*Medical Sentinel*" antedate those of medical history in California by many years.[†] After the death of its guiding spirit, the *Medical Sentinel* came upon rather difficult days. It was not until a broader concept was achieved and a manifest obtained for a complete reorganization of sponsorship and ideals that it assumed the vigorous growth factor which has carried it on in these brief years to its now important position as the *Western Journal*."

The statement that "the annals therefore of medical history in the Northwest as recorded in the *Medical Sentinel* antedate those of medical history in California by many years," was evidently made through oversight or lack of knowledge of medical journalism, as it found expression in California, commencing with the year 1856 (some four decades before the *Medical Sentinel* came into existence). For the information of those who may be interested, and for historical reference, the following list of medical publications of California is appended, compiled in part from "California's Medical Story," of which the late Henry Harris, M. D., of San Francisco, was the author:

1. *San Francisco Medical Journal*.
William H. Miller, editor and proprietor. San Francisco. V. 1, No. 1, January, 1856.
2. *California State Journal of Medicine*.
Dr. John F. Morse, editor and proprietor. Sacramento. V. 1, No. 1, July, 1856-April, 1857.
(Title reappeared 45 years later as the official

organ of the Medical Society of the State of California.)

3. *Marysville Medical and Surgical Reporter*.
Dr. Lorenzo Hubbard, editor. Marysville. V. 1, No. 1, 1858; V. 1, No. 2 (final number), 1860.
4. *Pacific Medical and Surgical Journal*.
John Trask, editor. San Francisco. V. 1, No. 1, 1858-1917.
5. *San Francisco Medical Press*.
1860-1865.
6. *California Medical Gazette*.
San Francisco. V. 1, No. 1, July, 1868-August, 1870.
7. *Western Lancet*.
San Francisco. V. 1, No. 1, 1872. (After 1879, was called *San Francisco Western Lancet*.)
8. *Pacific Journal of Health*.
1870-1872.
9. *California Medical Journal*.
Oakland and San Francisco. 1880-1908.
10. *California Medical Times*.
San Francisco. 1877-1878.
11. *Southern California Practitioner*.
Los Angeles. V. 1, No. 1, 1886.
12. *Pacific Record of Medicine and Surgery*.
San Francisco. V. 1, No. 1, 1886-.
13. *Medico-Literary Journal*.
San Francisco. 1877-1885.
14. "*Transactions of the Medical Society of the State of California*," Years 1870-1901.
When the "Official Journal"—(*California State Journal of Medicine*), was established in November, 1902, publication of the annual "Transactions of the Medical Society of the State of California" (former name of the California Medical Association), was discontinued.
15. *California and Western Medicine*.
November, 1902 (V. 1, No. 1)—Established in November, 1902, as "California State Journal of Medicine." Name changed to "California and Western Medicine" in March, 1924. "California and Western Medicine" is a continuation of the "*Transactions*," established in 1870. The date of Volume 31 of the "*Transactions*," was April, 1901.

"Essentials of Emergency Treatment": An Excellent Brochure by the Connecticut State Medical Journal.—During recent months several volumes have been published dealing with the subject of emergency practice, and with special relation to possible needs in civilian environments in the event of wartime casualties. Of such, the 144 page treatise recently brought out under the sponsorship of the *Connecticut State Journal of Medicine*, is one of the best.

Written especially for Connecticut physicians, its presentation of subject matter is of such appealing form and scope, that each of the nineteen sections—contributed in the main by well-known members of the faculty of Yale University School of Medicine—can be of equal value to physicians who are in practice in seaboard cities, on both the Atlantic and Pacific shores. The volume is commended to readers who may wish to possess such a compact book of reference.*

* The cost, in paper cover is \$1.00, in cloth covers, \$2.00; and the booklet may be ordered through the Connecticut State Medical Journal, 54 Church Street, Hartford, Connecticut. In the Book Review department of this issue, are listed the chapter titles.

* In current issue, see page 331.

† Italics by the editor of CALIFORNIA AND WESTERN MEDICINE.—ED.

EDITORIAL COMMENT †

SYNERGIC THEORY OF ANAPHYLAXIS

According to data recently reported by Kellaway and Trethewie,¹ of the Institute for Medical Research, Melbourne, Australia, there are two independent reacting mechanisms in acute anaphylaxis: (a) an explosive formation or liberation of histamine or histamine-like substances by the tissue proteins, followed by (b) the liberation of a second ergin or toxic factor derived from the tissue lipids.

Discovery of this hitherto unsuspected lipoidal anaphylatoxin was a by-product of researches on the pharmacodynamics of certain snake venoms. It has long been known² that in cobra-venom hemolysis, for example, laking of the red blood cells is not due to a direct action of the venom, but to its immediate action on lecithin. The lipolytic enzymes of the venom lead to the formation of a lecithin split-product ("lysocithin") which is directly hemolytic. This active hemolysin can be readily produced by the action of cobra venom on egg yolk or other lecithin containing materials *in vitro*. Chemically the "lysocithin" is a lecithin molecule robbed of one of its oleic acid radicles. The Australian investigators found that in a similar way contraction of smooth muscles under the influence of certain snake venoms is also due to the formation of certain smooth-muscle stimulating split-product of tissue lipids. This active split product or lipoergin can also be produced *in vitro* by the action of venom on egg yolk. The substance is soluble in acetone, by means of which it can be separated from "lysocithin."

The smooth-muscle contracting properties of this lipo-ergin are quite different from those of histamine. Tested on the isolated guinea-pig jejunum, for example, histamine produces an immediate maximum contraction with relatively prompt recovery. The lipo-ergin, in contrast, causes a slowly developing contraction only after a fairly long latent period, with a very sluggish recovery. For this reason the Australian biochemists refer to the lipo-ergin as a "slow-reacting smooth-muscle-stimulating substance" or "SRS."

Histamine and lipo-ergin apparently act on different elements in the smooth muscle. This is shown by a selective suppression of one reactivity by certain therapeutic agents. Exposure to B. welchii toxin, for example, will almost completely desensitize a smooth muscle to the lipo-ergin, without appreciably reducing its histamine sensitivity. Poisoning with relatively large doses of histamine may cause certain

smooth muscles to react to further doses by relaxation, whereas its lipo-ergin sensitivity is practically unaltered. Applying these and other selective depressants, Kellaway and Trethewie found that the typical anaphylactic response of smooth muscle can be analyzed into two components. First there is an initial histamine-like response. In this there is afterwards superimposed a typical slow lipo-ergic tetanus. Therapeutic blockade of both histamine and lipo-ergic sensitivity will prevent anaphylactic smooth muscle contractions, though suppression of either one of these is ineffective.

About ten years ago it was shown by Bartosch³ that if sensitized guinea pig lungs are perfused with Tyrode's solution plus homologous antigen, the hypersensitive tissues liberate histamine into the perfusion fluid. The Australian investigators found that this liberation is mainly confined to the initial stages of the perfusion. Thus in one of their tests, the first two 5 c.c. samples of the perfusion fluid contained a total of about 2.5 *gamma* histamine. There was a fairly large trace of histamine in the third sample, after which the samples became histamine-free. Analysis of the same samples showed no lipo-ergin in the first sample. Moderate amounts appeared in the second and third samples, with gradually diminishing amounts in subsequent samples.

The evidence, therefore, seems complete that there are two superimposed pathologic internal secretions in acute anaphylactic shock, both of which must be taken into account in any logical attempt at anti-anaphylactic therapy. The Australian physiologists believe that it is reasonable to assume that the same or a similar toxic lipoidal split-product may play an important rôle in other shock-like conditions, particularly in traumatic shock and superficial burns.

P. O. Box 51.

W. H. MANWARING.
Stanford University.

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MALPRACTICE INSURANCE*

At one time or another, during the last thirty years, a considerable number of insurance companies have engaged in writing physicians' professional liability insurance in California. That the business has not generally been profitable is evidenced by the fact that most of these companies no longer offer this coverage. The high incidence of malpractice claims and suits explains why this business is regarded as undesirable, even though the cost to the insured has increased

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

* Fourth of a series of articles on Malpractice Prophylaxis (Article I, in July issue, on page 7. Article II, in August, on page 121. Article III, in September, on page 173.)

considerably and limitation has been placed, by at least one company, on the amount of coverage offered.

Several factors have brought about increased insurance costs in this field. For example, the average trial time of malpractice suits has lengthened, and the cost of obtaining medical expert testimony has increased. During the past year several cases have required more than three weeks to try, and one case was in trial for more than six weeks. As must be expected when this type of trial is so absurdly long, the jury in the latter case was unable to agree upon a verdict.

Many busy physicians of great experience and the highest standing in their respective fields offer to, and actually do testify gratis in defense of their fellow practitioners; but, unfortunately, there are also "professional" medical expert witnesses who, if requested to testify for the defendant in an unjustified malpractice action, demand a large per diem fee.

Certain other factors contribute to the high cost of malpractice insurance in California; for it must be realized that, in the final analysis, the physician pays all of these costs. In those cases wherein there are multiple defendants, not uncommonly each of the two or more co-defendants is insured by a different company, or in Lloyds through different underwriters. Such a situation results in a duplication of legal costs, and certainly does not tend to increase the harmony and efficiency of the defense. Moreover, some carriers or their representatives utilize general insurance investigators and adjusters to investigate malpractice claims. These claims are not suitable for such handling. Finally, in too many cases malpractice insurance has been used as a sort of "come-on" to bring other business into the insurance company's office. This practice naturally obviates any reasonable or proper selection of risks.

In the final analysis, however, it is the physician himself who is responsible not only for the unsatisfactory insurance condition, but also for the continuing existence of the vicious malpractice situation. He is responsible, because he has been satisfied to pay his premiums and sit back complacently, doing nothing until he becomes the target for a malpractice claim. The physician must be brought to realize that his money payment is only a part of his insurance premium; the much more important part is his contribution of time, of study, and of putting into effect all possible measures to safeguard himself and his conferees.

The physician has apparently failed to understand that the problem of malpractice is *his* problem. Why should he expect the insurance companies to do his job for him? Why should the insurance companies care how high the premium rates climb, unless they become so high that the physician has to carry his own insurance? Representatives of some of the companies have so ex-

pressed themselves: they have said that if the physicians do not take an active part in their own behalf, conditions can be expected to continue along the present unsatisfactory course. Such a course will lead, in effect, to increased rates, decreased coverage, and a constantly increasing number of those regarded as uninsurable risks.

Few physicians, even when a malpractice claim is made or suit brought against them, take an active and intelligent interest in the matter. By way of illustration, within the last few months a physician who was served with a complaint and summons did nothing in regard to the matter for approximately sixty days. He did not notify his insurance carrier. Of course, in the meantime a judgment by default was taken.

The fact that a physician might reasonably expect the insurance carrier to make an immediate and thorough study of a claim does not excuse the physician for apathy and seeming indifference. Such a claim is a serious threat to him. He should insist upon its being handled immediately and efficiently. He must not lose sight of the fact that the attorney supplied by the insurance carrier is employed and paid by the carrier. These attorneys are very generally of the highest ability and integrity, but it is obvious that, to some extent, there may be divergence of interests on the parts of the insured and the insurer. The physician should make himself cognizant of every step in the development of his case.

Suggestions:

1. There should be a reasonable selection of risks, so as to eliminate the physician who will not realize his vulnerability and take the available precautions.

2. Reports should be required from insurance carriers so that the exact cost of malpractice insurance may be known to the medical group. This procedure would permit an equitable rate; moreover, it would thus be possible and proper to assess proportionate rates in respect to risks and cost in the various fields of medical practice.

3. Immediate and expert handling of all malpractice claims should be demanded.

4. Meritorious claims should be settled out of court.

5. The nonmeritorious claim should be fought to the last resort, and no claim should be settled because of its "nuisance" value.

6. The highest standard of defense should be demanded. The defense should be concentrated whenever several defendants are involved, thus reducing the cost and increasing the unity, harmony, and efficiency of the defense.

7. Physicians appearing as expert witnesses in malpractice cases should do so without fee, unless expense is incurred or special study or investigation is required. No charge should be made for appearing either on behalf of the defendant or the plaintiff. If both these things were done, the insurance costs of the defendant would be dras-

tically reduced, and subsidized, biased, and highly-colored testimony would be eliminated.

6777 Hollywood Boulevard.

LOUIS J. REGAN,
Los Angeles.

BIOLOGICAL SPECIFICITY OF RENIN

It is currently reported by Braun-Menendez¹ and his coworkers of the University of Buenos Aires, that renin, the recently demonstrated internal secretion from the ischemic kidney,² is species-specific, requiring a species-specific coenzyme for its activation. If so little or no therapeutic effect can be predicted from the use of lower animal renins in human medicine.

It was shown by Kohlstaedt and Page³ that this hypertension-precursor is activated by certain serum globulins, giving rise to a thermostable pressor substance, for which the name "angiotonin" has been suggested.⁴ In the hands of the Argentine endocrinologists globulin activation is readily effected *in vitro* by the action of horse serum, swine serum, ox serum or dog serum on swine renin. Swine renin, however, is not activated by human serum globulins. In order to bring about human activation human renin must be substituted.

This unsuspected species-specificity of the kidney enzyme (or of the serum activator) suggests that swine renin would be therapeutically inert in the human body. It also throws doubt of the current presumptive therapeutic value of certain other endocrine products, some of which conceivably may also require species-specific activation.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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The Home Front—Challenge to Medicine

Obviously, those in authority—the President, the Congress, and the Supreme Court—are weighing the evidence and are daily making the decisions that will determine the structure and functional changes, which, in turn, will guide our political and social future. Into the newer political and social structure of the country, organized medicine will necessarily have to fit its plans and concepts. . . .

The war may serve in this country as a substitute for those revolutionary mass movements which have been the usual manifestation of major social transition abroad. . . .

There is now developing a distinct challenge, as we have attempted to show editorially in preceding issues of the *Journal*, to the resourcefulness and fluidity of organized medicine. It must supply doctors for the armed

forces and is doing it; it must implement what we hope will be an expanding program of industrial medical service from a relatively small reservoir of physicians; it must study and meet the problem of adequate medical and hospital service to areas and communities which need it with the thought in mind that every community without private care is an argument for public medicine. Voluntary medical expense insurance plans must be activated and provide a far wider coverage than they have so far done.

Medicine has survived and flourished since time immemorial because of its ability to adapt itself to changing circumstances. Its only difficulty lies now, not in its inability to change its modes of thinking or of practice upon proof of necessity, but in the *rate* at which it can move to accomplish change. It must be conscious of the public necessity; it must carefully study the effect of public necessity upon the acts and attitudes of government and prepare to fit itself into the rapidly changing social order in as short a period of time as this can be done and yet be consistent with public safety.—*N. Y. State J. M.*, Vol. 42, No. 18 (September).

MEDICAL EPONYMS

Plaut-Vincent's Angina

Hugo Carl Plaut (1858-1928), of Leipzig published his "Studien zur bakteriellen Diagnostik der Diphtherie und der Anginen [Studies in the Bacterial Diagnosis of Diphtheria and the Anginas]" in the *Deutsche medizinische Wochenschrift* (20:920-923, 1894). A portion of the translation follows:

"Five successive cases of simple angina deserve mention because of the type of microorganism that, there seems to be no doubt, was their cause. . . . Inspection of the oral cavity, which contained many carious teeth, showed a dirty exudate on both medial surfaces of the markedly swollen tonsils and the left side of the uvula. . . . Microscopic examination of the exudate showed it to consist bacteriologically of nothing but Miller's spirochetes and Miller's bacilli. . . . Miller's bacilli are . . . much larger than the diphtheria bacilli, are, in contradistinction to these, pointed at the ends, and are always associated with the spirochetes, which apparently have some genetic relation with them. . . . These microorganisms of Miller's are found in small numbers in almost every normal mouth, but usually only under the gum margins. [The organisms referred to were described by W. D. Miller, an American physician and dentist in Berlin, in 1883.]"

H. Vincent (1862), military surgeon and bacteriologist, wrote "Sur une forme particulière d'angine diphthéroïde (angine à bacilles fusiformes) [On a Peculiar Form of Diphtheroid Angina (Angina with Fusiform Bacilli)]" in the *Bulletins et mémoires de la société médicale des hôpitaux de Paris* (15, 3rd series: 244-250, 1898). A portion of the translation follows:

"This angina is characterized by a grayish or whitish pseudo-membranous exudate, by the associated fever and occasionally rather marked adenitis. . . .

"If a bit of the pulpy exudate that appears on the surface of the pharynx is removed and stained with thionin or Ziehl's dilute fuchsin, microscopic examination shows two kinds of microbes to be predominant: a peculiar bacillus, easily recognizable by its length (about 10 to 12 microns) and its bulging central portion and distinctly tapering ends, and a delicate spirillum, more difficult to stain. This spirillum is quite similar to that normally present in the saliva and dental tartar."—R. W. B., in *New England Journal of Medicine*.

"Never before have we had so little time in which to do so much."—Franklin D. Roosevelt.

ORIGINAL ARTICLES

Scientific and General

HYDATIDIFORM MOLE AND CHORIONEPITHELIOMA*

MARGARET SCHULZE, M. D.

San Francisco

HYDATIDIFORM mole and chorionepithelioma are relatively rare conditions. Because they are so rare, and show such remarkable variations in clinical course, they are often poorly understood and therefore badly treated.

There have been, however, many advances in our knowledge of these two conditions in recent years and the present study is an attempt to summarize this knowledge. It is based upon the clinical and pathological findings in our own cases at the University of California Hospital, and upon a review of the recent literature.

SOURCE MATERIAL

We have observed sixteen cases of hydatidiform mole and eight chorionepitheliomas. Two cases appear in both groups; in one, a choriocarcinoma was present in the uterine wall, while the mole was still in the uterus; in the other, a syncytioma followed a mole under our observation. In two other cases of chorionepithelioma we were able to obtain slides of the preceding mole for study.

The pathological picture has been carefully reviewed in all cases. The moles were classified as benign or potentially malignant, according to the criteria of Hertig, while the chorionepitheliomas were divided into choriocarcinoma, choriodenoma and syncytioma, according to Ewing. Hormonal studies have been made on all cases since 1930; six of the moles and four of the chorionepitheliomas.

CLINICAL PICTURE

The clinical picture in the sixteen cases of hydatidiform mole was much as has been described in the literature. The ages of the patients with mole varied from twenty to forty-two years; only one patient was over forty and only four over thirty. The most frequent presenting symptom was irregular bleeding in association with a supposed pregnancy, while only two had no history of bleeding. All but two showed at least moderate anemia, and half of the patients showed leucocytosis of varying degree, the highest being 18,000. Sedimentation time varied from 35 minutes to 1½ hours for 18 m.m. in 9 cases.

Five of the sixteen cases had moderate nausea and vomiting, while four had hyperemesis. Two showed a preëclamptic toxemia.

Seven cases gave the classical picture of a uterus much larger than the supposed duration

of the pregnancy, and in three of these the rapid enlargement, while the patient was under observation, gave the clue to the diagnosis. Three cases had aborted the mole a few days previous to admission; in two cases the size of the uterus corresponded to the estimated duration of pregnancy; in one the duration of pregnancy was unknown; while in three the uterus was actually smaller than it should have been.

Lutein cysts were recognized in six of the women, in four from one to two months post partum.

Vesicles were not observed in any case before actual evacuation of the mole, although looked for many times.

The x-ray was used as an aid in diagnosis in four cases in which the uterus was larger than it should have been for the estimated age of the pregnancy. No evidence of a fetus was found in any of these. Chest x-rays were taken in three cases of patients who entered shortly after passing the mole. None showed evidence of pulmonary metastases.

TREATMENT

Thirteen patients were treated by simple evacuation of the uterus, after spontaneous, instrumental or bag dilatation of the cervix, or after vaginal hysterotomy. Two cases had immediate hysterectomies, one because of a fibromyoma, another because of a complicating choriocarcinoma. Still another had a hysterectomy a few days after instrumental evacuation of the mole, because the pathologic picture of the mole so strongly suggested malignant tendencies. The removed uterus showed no evidence of chorionepithelioma, and the Aschheim-Zondek test taken just preoperatively was negative. This was in the early days of the Aschheim-Zondek test before it was realized how much reliance could be placed upon it.

Two patients received radium, one a dose of 639 mch for bleeding one month following her mole. This woman later had two pregnancies, one full-term, one early therapeutic abortion. One woman received 1516 mch because of complicating fibroids, with permanent amenorrhea resulting.

COMMENT

Three patients were readmitted to the hospital for study because of symptoms suggesting the development of a chorionepithelioma. One of these had a chorionepithelioma of the syncytial endometritis type of Ewing; in the other two, chorionepithelioma was ruled out by curettage, substantiated in one case by negative hormonal studies.

None of the sixteen patients died as a result of the mole or its sequelae. One thirty-seven year old woman died, two years after her mole, of carcinoma of the hepatic duct. All the rest are known to be well at the present time except three, and these had been well for seven, ten, and fifteen years respectively, following their

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From the Department of Obstetrics and Gynecology, University of California.

mole when last seen.

Since four of the women had hysterectomies at the time of their mole or shortly thereafter, and one had a sterilizing dose of radium, the possibility of further pregnancies remained in only eleven. One of these died two years after her mole of carcinoma of the hepatic duct; of the remaining ten, nine had from one to four further pregnancies and none had a second mole.

Of the eight chorionepitheliomas, three were choriocarcinomas, two chorioadenomas, one a syncytioma, and one a case with pulmonary metastases in which the type of the primary lesion could not be classified with certainty.

Only one died—a patient with choriocarcinoma, who entered the hospital in practically moribund condition with vaginal and generalized abdominal metastases. The blue vaginal nodule was noticed by her physician at the time of curettage two months earlier, but its serious significance was apparently not realized until it began to take on very rapid growth and to slough six weeks later. In contrast to this patient was another who was referred for treatment immediately upon detection of a vaginal metastasis, while her physician was curetting her for a mole. With prompt radical operation this woman remained alive and well eight years later.

The great variability in behavior of both moles and chorionepitheliomas has led to numerous attempts on the part of pathologists to correlate the microscopical with the clinical picture. Opinion on this subject is very much divided. A very careful review of our material leads us to the conclusion that, although pathologic examination of the mole for the criteria of potential malignancy is often suggestive, it cannot be depended upon for practical purposes.

The pathological picture in three of the four cases of chorionepithelioma in which slides of the original mole were available fulfilled some of the criteria of potential malignancy as outlined by Hertic, but in one case the mole appeared of distinctly benign type. Furthermore, in four of the cases without malignant sequelae, the histologic picture was far more suggestive of potential malignancy than in any of the four with them. In one case this pathologic picture led to removal of the uterus which showed no evidence of chorionepithelioma.

We feel, therefore, that no matter how benign the microscopic picture, every mole must have a careful follow-up to detect at the earliest moment the possible development of a chorionepithelioma; yet, on the other hand, no mole should be considered actually malignant without corroborative evidence, and this will be furnished by the biologic pregnancy tests.

The proper interpretation of these tests is, however, not always simple. When it was first discovered by Zondek and by Meyer that hydatidiform mole and chorionepithelioma gave un-

usually high values of gonadotropic hormone in the urine it was felt by many that diagnosis had become a simple matter of quantitative estimation of this hormone, in spite of Aschheim's warning to the contrary. The interruption of a number of cases of normal twin pregnancy, and one triplet pregnancy where too rapid enlargement of the uterus plus high hormonal values had led to a diagnosis of mole, showed that the matter was not so simple as this. In 1937, Evans, Kohls and Wonder reported the normal occurrence of transient extremely high levels of gonadotropic hormone in the blood and urine of early pregnancy, and this work was confirmed by Palmer and others. A peak value is reached some time between the twentieth and the fiftieth day after the first missed period, which may equal or exceed any value as yet reported in hydatidiform mole or chorionepithelioma. However, following the peak, there is a very abrupt drop in hormone concentration, so that in all but one case values remained below 10,000 rat units per liter after the 65th day of pregnancy. For this reason Palmer feels that unusually high hormonal values in a pregnancy definitely past the first trimester would, in all probability, be diagnostic of mole.

The fact that the Aschheim-Zondek reaction may remain positive for many months after the passage of a mole, although it disappears within a week after the termination of a normal pregnancy, has long been recognized. Two explanations have been offered for this phenomenon: that of Phillip and Sigmund, who believe that the prolonged excretion is due to slow release of stored hormone from the accompanying lutein cysts, and that of Brindeau, Hinglais and Hinglais who feel that chorionic epithelium may persist for a considerable time in the uterine wall without undergoing malignant change, and may continue as a source of hormone. According to present opinion repeated quantitative estimations of chorionic gonadotropic hormone are our only means for the early detection of chorionepithelioma following mole. A single positive test, even many months later, is of no value whatsoever. So long as the titre is decreasing, or at least remains constant, we may safely observe the patient. If malignant change does occur, there is a sudden abrupt rise in hormone titre, sometimes after it has remained at a low point for a considerable length of time. With sufficiently frequent observation, this malignant change may be detected in ample time for radical treatment, and in one of the cases of Brindeau, Hinglais and Hinglais it occurred while the chorionepithelioma was still the size of a pea. Whether or not there may be a reappearance of hormone and malignant change after the hormone has once entirely disappeared is still a controversial point. Brindeau, Hinglais and Hinglais found no recurrence after complete disappearance, although they did find it after the hormone had reached very low levels, and with this most authorities agree. In one of our cases

the hormone reached such a low point that it required concentration methods to demonstrate it before the abrupt rise signaled the onset of the chorionepithelioma.

That the sudden abrupt rise in hormone titre may be due to the development of a new pregnancy rather than a chorionepithelioma must never be forgotten. Otherwise there is danger of interrupting a normal pregnancy or even of extirpating the pregnant uterus of a healthy young woman. Ordinarily clinical methods will establish this diagnosis readily enough if the possibility is kept in mind.

Until recently a positive reaction for chorionic gonadotropic hormone in the spinal fluid has been accepted by many as diagnostic of hydatidiform mole or chorionepithelioma, although very few studies had been made in normal pregnancy, and Hashimoto had reported positive Aschheim-Zondek reactions in five cases of normal pregnancy using from 18-20 c.c. of cerebrospinal fluid. Recent studies by Palmer, in the University of California Gynecologic Endocrine laboratory, showed six positive reactions for chorionic gonadotropic hormone in the cerebrospinal fluid among forty-two normally pregnant women, and one negative spinal fluid reaction in a woman with choriadenoma.

It is therefore apparent that no one hormonal test suffices to establish absolutely the diagnosis of either hydatidiform mole or chorionepithelioma, no matter how high the value or whether it be made on blood, urine, or spinal fluid. Repeated quantitative determinations are of the utmost value in the follow-up of hydatidiform mole, and a sudden increase in titre after it has dropped to a low level is most suggestive of the development of a chorionepithelioma, providing always that the onset of a new pregnancy can be ruled out.

Complete disappearance of the hormone within a month after evacuation of a mole is the rule. However, long persistence of a positive reaction after a mole is in itself of no serious significance providing the titre is decreasing or at least remaining stationary, but an increase in titre must be most carefully evaluated at once. Weekly quantitative determinations and clinical examination are essential at first, and will allow the detection of malignant change in adequate time for successful treatment. After the test has once become entirely negative, even in a concentrated specimen, it will probably remain so, but further data upon this point are still needed before this can be stated dogmatically. Certainly so long as a positive value persists, even though a very low one, continued follow-up studies are essential.

University of California Hospital

Chance favors the prepared mind.—*Pasteur.*

Diagnostic errors are more often due to laziness than to ignorance.

One thing the consultant can always do that has not been done—a rectal examination.—*Osler.*

WAR DERMATOLOGY: SOME GENERAL ASPECTS*

SAMUEL AYRES, JR., M.D.
Los Angeles

THIS paper is part of a symposium prepared by the Committee on War Dermatology of the Los Angeles Dermatological Society, the purpose of which is two-fold: First, to acquaint the dermatologist with some of the problems which he is likely to encounter in the immediate future in either civilian or military practice; and second, to acquaint the medical profession with the part which dermatologists are ready and able to perform in this emergency.

The symposium included discussions on the treatment of burns, war gases, contact dermatitis, syphilis, and infections and infestations. This paper concerns itself with the diagnosis and treatment of some of the more common infections and infestations.

Cutaneous disorders due to infections and infestations, while frequently of a minor nature, are of considerable importance for the following reasons:

- (a) Large numbers of men are frequently affected by parasitic infestations, with a consequent lowering of efficiency and morale.
- (b) Many of the parasites are capable of transmitting contagious and epidemic diseases.
- (c) Secondary pyogenic infections are common, and may be serious and disabling.

1. Pediculosis corporis

Parasite—*Pediculus humanus corporis*.

Incidence—Extremely common under war conditions.

Symptoms—Itching, urticated papules, linear scratch marks, superficial pustules, deep abscesses, ecthyma, melanoderma, vitiligo. Eggs in underwear, clothing, but may be attached to body hairs.

Treatment

- (a) Hot soap and water bath, followed by suitable application to kill eggs which may be attached to body hairs, as Cuprex (Merck) which is allowed to remain on skin for 30 minutes and washed off, or
- (b) Rotenone lotion (2 per cent) which has been found effective in treatment of scabies, chigger bites, and other insect pests. Has not had extensive trial in pediculosis. (See under Chiggers.)

Prophylaxis

- (a) Disinfection of clothing by steam at 220° F. at 5 lbs. pressure for 30 minutes.
- (b) Possibly the occasional applications of 2 per cent rotenone lotion might discourage infestation.

* Read before the Section on Dermatology and Syphilology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

2. Pediculosis pubic and pediculosis capitis

Parasites—*Phtirus pubis* (crab louse) and *pediculus humanus capitis*.

Incidence—Much less than pediculosis corporis, but fairly common under unhygienic conditions.

Symptoms—Itching, nondescript excoriations, secondary pyoderma, enlarged lymph nodes, involving respective areas. Pediculosis pubis may involve axillae and other hairy portions of body. Eggs fastened to hairs, white in case of pediculosis capitis, brownish in case of pediculosis pubis. *Pediculus pubis* attaches itself to the skin and appears as small, scale-like object.

Treatment

- (a) Cuprex (Merck), a compound, containing copper in liquid paraffine and acetone and tetralin, applied for 30 minutes and then washed off. Should be repeated for 3 or 4 days.
- (b) Petroleum rubbed in and washed off after 24 hours.
- (c) Tincture of larkspur rubbed in and washed off after 12 hours.
- (d) Calomel dusting powder, 10-20 per cent in talc for pediculosis pubis.
- (e) Rotenone lotion (2 per cent). Apply twice daily for 3 to 5 days.
- (f) Comb hair with fine comb dipped in warm vinegar.

Prophylaxis

- (a) Pediculosis pubis is often of venereal origin; therefore, simple cleanliness usually effective before infestation becomes established.
- (b) Sterilization of hats, combs, brushes, underwear, etc.

3. Scabies

Parasite—*Sarcoptes scabiei*

Incidence—Very frequent under crowded and unhygienic conditions, as in war and among refugees.

Symptoms

- (a) Burrows, vesicles and pustules on hands, wrists, feet.
- (b) Excoriated papules and crusts on body, except face.
- (c) Nodules, usually excoriated, on elbows, anterior axillary area, lower abdomen, genitals, buttocks, breasts (female).
- (d) Secondary pyoderma.
- (e) Itching, especially on retiring.

Treatment

- (a) R_x — Betanaphthol 8.
Sublimed sulphur 16.
Balsam Peru 60.
Petrolatum 60.

The patient is instructed to take a warm bath with soap each night and morning for three days, and following the bath each night, the above ointment is applied to the entire body, except

the face. No ointment is applied during the day. Clothing is sterilized by dipping in a cleaning solvent, and the underwear and linens are boiled. Occasionally it is necessary to repeat the ointment for three nights on the hands and wrists only.

- (b) If secondary pyogenic infection is a prominent feature, it may be necessary to treat this before undertaking antiscabetic treatment, but this is seldom necessary.
- (c) Rotenone lotion (2 per cent) applied twice daily for 2 to 7 days to entire body, except the face.

Prophylaxis

- (a) Treat all affected cases.
- (b) Scabies is frequently of venereal origin, therefore, simple cleanliness usually effective before infestation becomes established.

4. Chiggers (*Trombidiosis*): "red bug," harvest mite, *leptus*

Parasite—*Trombicula irritans* (U. S.), *Trombicula autumnalis* (Europe). Larva attaches itself to skin for 3 or 4 days, secreting a substance which digests or liquefies the epidermis, which it then eats.

Incidence—Common in warm, humid regions of the world, and in Central and Southern U. S. during June, July and August. During maneuvers in Southern U. S. in the summer of 1941, over 75 per cent of troops were affected.

Symptoms—Intolerable itching. Lesions mostly on legs. Indurated papules, papulovesicles with redness, induration and swelling, and large blebs; secondary pyoderma.

Treatment and prophylaxis

- (a) R_x — Precip. sulphur 1 part
Vanishing cream base 4 parts
- (b) 2 per cent Rotenone lotion (Abbott)
Rotenone 2%
Chloroform 5%
Aqueous mucilage of Irish moss and quince seed, q.s. . . . 100%
To be applied before and after exposure.

5. Chigoe infestation

Parasite—*Tunga penetrans* (chigoe flea). Resembles common flea, but smaller, poor jumper.

Incidence—Widely distributed in tropical and subtropical countries.

Symptoms—Female burrows into skin about toes and feet, and while pregnant, swells to size of pea. Produces papules, nodules, ulcers, secondary pyoderma. Considerable itching and pain.

Treatment

- (a) Extract flea with point of needle and dress wound with suitable medicament.
- (b) Apply phenol to parasite.

Prophylaxis

- (a) Warm soap and water bath immediately after exposure.
- (b) Wearing shoes very important, since parasite seldom attacks above dorsum of foot.
- (c) Scrupulous cleanliness of rooms and camp.
- (d) Contact insecticide spray, such as: Three parts of soft soap are thoroughly melted by heat in 15 parts of water, and while still hot, 70-100 parts of oil (petroleum, kerosene or paraffine) are added gradually, with much shaking and stirring. The proper emulsification depends upon the *gradual* addition of the oil and thorough agitation. The final mixture should be white and creamy, with no free oil. For use, dilute 1 part with 20 or more of water. (Gordon.)

6. Flea bites

Parasite—*Pulex irritans* (human flea) and other fleas, such as dog flea, cat flea, tropical rat flea (plague).

Incidence—World-wide, although some regions, such as Mexico, California, etc., appear to be more infested. Animal fleas also occasionally attack humans.

Symptoms—Groups of itching, wheal-like papules, with central hemorrhagic or excoriated punctum. Since one insect frequently makes 2 or 3 bites in succession, each lesion in a group will be of the same age, and each group of a different age.

Treatment—Calamine lotion with 1 per cent phenol.

Prophylaxis—Contact insecticides, sulphur fumigation. Difficult to destroy fleas living out-of-doors. Two per cent rotenone solution.

7. Grain itch

Parasite—*Pediculoides ventricosus*, a small mite which does not burrow under skin.

Incidence—Infected straw, straw mattresses, etc. Usually May to October.

Symptoms—Widely-spread eruption of wheals with central pin-point vesicle. Vesicle may become turbid or pustular. May resemble chicken pox. Face, hands and feet usually free. Severe itching, mild fever at times.

Treatment

- (a) Local—see Scabies
- (b) Sterilization of clothing and straw mattresses, etc., as in scabies or by sulphur or formaldehyde fumigation.

8. Bedbug bites

Parasite—*Cimex lectularius*

Incidence—World-wide, under unhygienic living conditions, as might prevail among refugees, etc. Parasite found in mattress, bed, cracks in floor, etc.

Symptoms—Similar to that of flea bites.

Treatment—Similar to that of flea bites.

Prophylaxis—Similar to that of flea bites.

9. Tick-bites

Parasites—*Ixodinae* and *Argasinae* (wood tick).

Incidence—Widespread, especially in woods and underbrush.

Symptoms—Itching. Tumor-like swelling, due to firmly attached body of tick, which is distended with blood.

Treatment—Do not attempt to pull the tick off, since the head may break off, remaining in skin and causing inflamed and infected wound. Placing several drops of any oil over the tick will cause it to relax its hold, so that it may be detached. Calamine lotion.

Prophylaxis—Full protection of body by clothing.

10. Uncinaria dermatitis (ground itch, hook-worm)

Parasites—(*Ankylostoma duodenale*
(*Necator Americanus*)

Incidence—Larvae found in sand and dirt, deposited from intestinal canal of infected persons. Warm areas—Southern U. S., Puerto Rico, East Indies, Japan, Australia, Ceylon and South America.

Symptoms—Lesions usually on feet, especially soles and between toes. Itching, redness, swelling, papules, papulovesicles and bullae. Secondary pyoderma.

Treatment—Locally symptomatic. In early lesions, salicylic acid in collodion, 1 to 8. Systemic—thymol, etc.

Prophylaxis—Adequate sanitation, wearing shoes.

11. Creeping eruption (Larva migrans)

Parasite—Larva of *Ankylostoma Braziliensis*, *Catrophilus* larva (Bot-fly) and probably several other species.

Incidence—Southern U. S., Russia, etc., during summer; (in U. S., especially on sandy beaches).

Symptoms—Progressively extending, irregular, thread-like line, due to migrations of parasite through epidermis. Line is narrow, slightly elevated, light-red early, dark red later; may begin as papule, vesicle or simple redness, may have beaded appearance or may contain vesicles. Lines may be straight, wavy or looped and may extend at rate of 1 inch or more a day. Lesions frequently begin on hands, face, buttocks or genitals, or feet. Itching or stinging sensation.

Treatment

- (a) Freezing with ethyl chloride or CO₂ snow.
- (b) Remove parasite at advancing margin of line by needle or shaving off burrow with safety razor blade.

Prophylaxis—Control of infestation in dogs and cats, which by defecation deposit the parasite (in the case of *Ankylostoma Braziliensis*).

12. Bacterial Infections

Organism—Staphylococci, streptococci.

Incidence—Extremely common, especially following simple traumatic wounds, abrasions, etc., and secondary to pediculosis, scabies, insect bites, epidermophytosis, etc.

Symptoms—Impetigo, nondescript pyodermas, ecthyma, ulcers, abscesses, furuncles, cellulitis, etc.

Treatment

Local

(a) Open and drain pus and remove crusts.

(b) Alibour solution wet dressings.

Rx — Copper sulphate 1.6

Zinc sulphate 5.6

Sat. sol. camphor water,
ad. 240.0

Sig: Dilute 2 tablespoons to a glass of water and apply as wet dressings.

(c) Rx 5 per cent Sulfathiazol ointment, as produced by reputable pharmaceutical houses.

(d) 5 per cent ammoniated mercury ointment.

Systemic—Where infection is severe, or septicemia present, sulfathiazol by mouth.

Prophylaxis—2 per cent aqueous solution of gentian violet applied immediately to all trifling, superficial wounds. Do not apply mercury and iodine consecutively.

13. Fungus Infections

Parasite—Various strains of trichophyton most common.

Incidence—Very common. In Navy, 1929-38, second most common skin disease, and eleventh in incidence of diseases in general. Frequently acquired by walking barefoot on infected floor.

Treatment—Whitfield's ointment and Castellani's carbolfuchsin paint are two satisfactory local measures, which, however, must be used either singly or alternately over a period of at least two to four weeks. Cases of trichophytosis due to trichophyton purpureum, usually characterized by the dry, scaly involvement of both soles, and one hand and frequently the nails, are practically incurable at the present time, and those infected should probably be considered unfit for military service.

Prophylaxis—Frequent foot inspection, treatment of incipient cases and carriers, such as those individuals having chronically-infected nails, effective disinfection of shower-room floors, foot dips of sodium hypochlorite (1 per cent) in shower-rooms, and formaldehyde fumigation of infected shoes, with subsequent airing of shoes be-

fore being worn again. Foot powders, which may be applied occasionally after bathing, such as

Rx — Salicylic acid 2½%
Benzoic acid 2½%
Chlorothymol 1/25%
Borated talc 100%

SUMMARY

No originality is claimed for any of the subject matter in the above paper. The conditions which have been briefly outlined represent those conditions coming within the scope of dermatology which, in the past, have frequently been encountered under war conditions, and which the dermatologist therefore should be prepared to treat.

Doubtless some conditions have been omitted from consideration which, under certain circumstances, have been important, and many new problems may be encountered in the present conflict.

The inadequacy of some of the current methods of prophylaxis and treatment of certain of these conditions, notably pediculosis corporis, offers a standing challenge to the ingenuity of the dermatological profession. Instead of cancelling or postponing some of our local or national meetings, a great deal might be accomplished if a concerted effort were directed toward improving and standardizing the methods of treating burns, contact irritants, syphilis, infections, infestations, etc.

2007 Wilshire Boulevard.

CALIFORNIA STATE BOARD OF MEDICAL EXAMINERS *

HOW FUNDS RECEIVED FROM PHYSICIANS ARE EXPENDED

DWIGHT W. STEPHENSON

Sacramento

TAXES, license fees and service charges are an integral part of our economic structure. Our citizens are today more tax-conscious than ever before. A greater proportion of our population now pay more taxes or fees than they ever paid before for the support of the various arms of government, local, State and Federal; and when a requirement to pay for the services of government reaches our pocketbook—we ask "why?"

Of the many agencies of government regulating our daily lives, one is the State Board of Medical Examiners created April 3, 1876. Those of the medical profession may properly ask, "Why regulate us?" That is equally true of all the other professions, vocations and businesses. We find that at each succeeding session of the

* Author of this article, Dwight W. Stephenson, is Director of the California State Department of Professional and Vocational Standards. The California State Board of Medical Examiners is one of the examining boards operating under the supervision of the "State Department of Professional and Vocational Standards."

Legislature, bills are introduced not only creating additional agencies, but measures designed to strengthen and broaden the scope of existing law and eliminate loopholes found in the progress of administering the law.

Regulatory measures such as this have rightfully received recognition from our lawmaking body for two purposes: (1) To protect the public from the unscrupulous practitioner and (2) to afford a maximum of protection to the ethical, legitimate practitioner against bad or ruinous practices of his competitors. It might be added that a third purpose would have as its goal the elevation of the profession of which each is a part.†

Since we have this type of agency, it becomes necessary to finance its activities without placing undue burden upon the general taxpayer. Special in nature, its operation and support must come from the sources concerned—the physician and surgeon.

That is why the State Board of Medical Examiners is self-supporting. It does not cost the general taxpayer one cent to maintain, and I hazard the guess that physicians' fees would not be one penny less if a license were not required.

PURPOSE OF PRESENT ARTICLE

It is my purpose in this article to graphically illustrate the financial side of the operation of this Board, in order that you may better understand why some things are done, and why others are not done which the profession may consider necessary or essential.

All moneys collected under the act are received by the Department of Professional and Vocational Standards and deposited in the State Treasury to the credit of the State Board of Medical Examiners. For the year July 1, 1940, to June 30, 1941, the amount collected was \$68,592.50. Prior to each session of the Legislature, this department is required to prepare our estimate of expense and income (budget) for the ensuing period commencing July 1 and ending June 30, two years later. With rapidly changing times, it is almost impossible, and certainly highly improbable that the estimates can be much better than a guess.

But we submit our estimates to the Department of Finance which in turn submits them to the Legislature. Further consideration follows in the legislative committees, at which time we must justify each item of expense proposed by us. •

† Note. For a brief outline of the history of Medical Practice Acts of California, see "Directory of State Board of Medical Examiners," edition 1942, on page 25. These laws were brought into existence through the efforts of organized medicine, as represented in particular by the State Medical Association of California. For information concerning the "Business and Professions Code," of which "Division 1, Department of Professional and Vocational Standards" is a part, and the present Medical Practice Act, see in the same Directory, on page 365. In the same publication, a table of references to various practice laws and amendments thereto appears on page 410. This information for readers who may wish to refer to some of the source material.—Ed.

Although we have ample moneys in the fund, the Legislature reserves the right to determine how much, for what purpose, and the extent to which we may spend this money. It never authorizes more than we request and generally reduces it. (Example—we have \$300,000 in the bank, but authority to spend only \$200,000. Therefore, \$100,000 remains in the bank and serves no purpose.) Even with an intimate knowledge of our requirements, and all the appeal possible, we are helpless, unless the Legislature heeds our request.

BIENNIAL BUDGETS

To be more specific, I shall give you the exact picture of the program presented to the last Legislature. Our expenditure request to the Department of Finance for the two year period was \$157,522.00. That Department reduced our request by \$1,980.00. The Legislature accepted the figure of the Department of Finance and made an appropriation for the biennium July 1, 1941, to June 30, 1943, of \$155,542.00. We were limited in our expenditures to three classifications, i.e., Salaries and Wages, Operating Expenses and Equipment. This was an entirely new budget program and one which hampers and restricts a good business administration of the agency.

With the appropriation of \$155,542.00 for the period July 1, 1941, to June 30, 1943, we have available, for each year, one-half of that sum or the sum of \$77,771.00. We then presented a working budget to the Department of Finance of \$77,771.00. This sum cannot be augmented in any manner except through the granting of a deficiency by the State Board of Control, and approval of the Governor. Such authorization is only considered in the light of work or program which could not be anticipated at the time the budget was presented.

HOW PORTIONS OF LICENSE FEES RECEIVED FROM PHYSICIANS ARE ALLOCATED

Now what does the budget contemplate, and how will the money be spent? It provides for the expenses of ten board members; a secretary, four special agents, eight office employees and temporary help. We have the usual operating expenses, such as rent, postage, travel, telephone, telegraph, fiscal expense, printing and equipment. All of this costs money and it is my conviction that the fees paid by the profession for this service should be used for those purposes and not be allowed to accumulate in the State Treasury to be of no use to anyone.

The Medical Practice Act provides that the Director of the Department of Professional and Vocational Standards shall designate a sum for each fiscal year to be transferred to the department fund. As the Board's share of the cost of administration of the department for the fiscal year 1941-1942, the assessment so levied was the sum of \$2,000.00. This procedure obviates

the necessity of each board comprising the department maintaining a staff of clerical help to handle the finances of each board and is a real economy in government.

Since this agency is not dependent upon general taxes for support, the money collected by it is used for but one purpose—that of protecting the public and ethical practitioners. The type of service demanded is one thing. Our ability to render that service is dependent entirely upon the availability of funds.

We can only cover the large State of California as effectively as finances will permit, for after all the entire subject relates to manpower.

How do we get this financial support? The answer—only from the physicians. Every person applying for a license submits to an examination for which he pays a fee. If he passes the examination and is otherwise qualified he may practice as long as he renews the license. All receipts are properly accounted for, and expended only as authorized by law.

BUDGET FOR JULY 1, 1941 - JUNE 30, 1942

The following is a detail of expenditures of said board by function and object for the fiscal year July 1, 1941, to June 30, 1942.

Administration

Salaries and Wages	
Board Members	\$ 5 300 00
Executive	4 800 00
Office	14 380 00
Directory	2,985 00
Examination	400 00
Inspection	11 640 00
Legal	2,500 00
Temporary Help
Total Salaries and Wages.....	42,005.00
Operating Expense:	
Materials and Supplies	
Office	550 00
Printing	1,650 00
Directory	4 500 00
Total Materials and Supplies.....	6,700 00
Service and Expense	
Travel	8,300 00
Office	650 00
Telephone and Telegraph.....	1 350 00
Postage	3,150 00
Freight, Cartage and Express.....	160 00
Rent	6 128 00
Departmental Administration	2 000 00
General Fiscal Administration.....	550 00
Attorney General	4,000 00
Personnel Board Pro Rata.....	220 00
Insurance Premiums	220 00
Examination	800 00
Hearings and Evidence.....	1 033 00
Total Service and Expense.....	28 561 00
Total Operating Expense.....	35,261.00
Property and Equipment	
Office	115.00
Total Property and Equipment.....	115 00
Total Administration	77,381.00
Total Expenditures	77,381.00
Recapitulation:	
Salaries and Wages.....	42,005.00

Operating Expenses:

Materials and Supplies.....	6 700 00
Service and Expense.....	28 561 00
Total Operating Expenses.....	35,261 00
Property and Equipment.....	115 00
Total Expenditures	77,381.00

To say that the law has accomplished only that specifically represented by the foregoing figures is incorrect, because the mere fact that the law is upon the statute books is, in my opinion, its principal value as a deterrent to would-be offenders, and of course this latter is immeasurable.

1020 N Street.

WAR GAS INJURIES OF THE EYE*

EDMUND D. GODWIN, M. D.

Long Beach

ALTHOUGH we of the University of California profess no actual experience with injuries of this nature, present conditions demand that we look into the problems of chemical warfare in order to prepare ourselves for an emergency which may arise at any moment.

The use of poison gas as an agent of warfare is relatively new, having been introduced in 1915 when the Germans released chlorine in Flanders.¹ Since then, other agents have been investigated, but few have seen actual war use. The term "gas" is construed by general usage to include many substances, whether they are used as a solid, liquid, or gas. Significant of possibilities is the recent manufacture of over 200,000 tons of these agents by warring nations.²

MUSTARD GAS

In war, the only agent which so far has resulted in serious eye lesions is mustard gas.³ Our knowledge of war gas injuries of the eye, therefore, is mainly the understanding of this substance⁴ and its effect on ocular tissues.⁵ It exists as a clear, oily fluid with a faint odor resembling mustard, garlic, or horseradish. It may be distributed by artillery shell, trench mortar bomb, grenade, or, more efficiently, by aerial bomb and actual spraying from low-flying airplanes. Casualties result from contact with droplets or varying concentrations of vapor. While moderate amounts of gas can be detected by smell, a concentration as low as one in 10,000,000 parts in the atmosphere insidiously dulls the olfactory sense, and exposure is effected without recognition. Mustard gas is especially soluble in animal fat, which accounts for its rapid penetration into skin and lid margin. It is not dissolved in lacrimal secretion, but acts upon cornea and conjunctiva as a protoplasmic poison, extending damage from cell to cell deep into the tissue. Mustard gas vaporizes slowly, and its emanation from contaminated articles forms a continued source of danger. Re-

*Read before the Section on Eye, Ear, Nose and Throat, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

peated minimal exposures are cumulative in their effect.

After exposure to mustard vapor, a latent period of from two to forty-eight hours precedes symptoms; if liquid is contacted, almost immediate discomfort is experienced. A burning sensation is followed by pain in and about the eye, accompanied by a sandy feeling under the lids. Lacrimation is profuse, and blepharospasm may be intense enough to dam back the tears and prevent voluntary opening.

CLINICAL PICTURE

The clinical picture^{2, 3} of the victim of mustard gas varies in severity as the degree of exposure, and for academic and practical purposes, the cases have been divided depending on the existence of visible corneal involvement: 75 to 90 per cent of all cases are mild, showing conjunctival congestion, especially in the palpebral aperture. The lids are edematous along the margins where the fatty meibomian secretion renders them susceptible. In two weeks these cases have completely recovered. Ten to 25 per cent of cases, however, although ushered in with comparable symptoms, develop more intense reactions. The exposed cornea becomes devitalized, revealing an "orange-peel" texture, or it may be eroded. Iris spasm produces miosis. Surface conjunctiva is destroyed, and the resulting necrotic membrane, as well as its underlying coagulative exudate, may exert enough tissue pressure to blanch the circulation and prevent chemosis. The remainder of conjunctiva is effected less, and may be chemotic to the extent of prolapse. During resolution, the pale area corresponding to the palpebral aperture (which may be mistaken at first for the more normal area) gains chemosis, as pressure is released, before final blanching occurs. Convalescence is gradual and may require several months.

PATHOLOGY

The pathology of severe corneal burns with mustard gas has been described in the rabbit^{5, 6} and in man.⁷ Epithelium is destroyed immediately, and within fifteen minutes, edema and necrosis of stroma follow. After five hours, polymorphonuclear infiltration appears at the limbus and spreads into the stroma. A week later, edema subsides, and the opacity improves. Vascularization of the area continues for weeks. After several years, the area may be subject to recurrent ulceration. Fibrosis forms the picture of healing.

Prophylaxis⁷ is gained by immediately adjusting the gas mask when the faint, transitory mustard or garlic odor is detected, or if other reason exists to suspect the presence of mustard gas. Medical attendants should wear respirators while caring for gas casualties before they and their clothes have been decontaminated. Periodic irrigation of the eyes with sodium bicarbonate solution is practiced several times daily by workers in English mustard factories.

TREATMENT

Treatment after exposure is useless to prevent a lesion. If therapy is begun within fifteen minutes of exposure, dichloramine-T as a $\frac{1}{2}$ per cent solution in chlorinated paraffin may be valuable as a mild neutralizing agent, but local anaesthesia must be used. A most important phase of treatment is reassurance. The patient who cannot open his eyes may fear he is blind; the lids should be opened to show him that vision is not lost. The conjunctival sac is irrigated to decrease bacterial flora. A variety of solutions is proposed, but any bland lotion such as normal saline, 2 per cent boric acid, or 2 per cent sodium bicarbonate may be used three times daily. If tears are imprisoned by blepharospasm, their periodic release is essential. A bandage is contraindicated; dark goggles or an eyeshade is recommended. Atropine is employed as in other corneal wounds. Mineral oil is instilled in severe cases to prevent adhesions, but should not be used before leaving gassed areas, as the oil serves to concentrate more mustard. During convalescence, $\frac{1}{4}$ per cent zinc drops with adrenalin are advised.

OTHER GASES

Comparatively little is known from war experience of other gases dangerous to the eye. Lewisite has been used in the present Chinese-Japanese campaign, and reports are current that a mixture of mustard and lewisite was used by Japanese landing troops on Malaya. Lewisite is a vesicant similar in properties and action to mustard gas, but has, in addition, the toxic ingredient of arsenic. Ocular lesions are similar to those caused by mustard, although symptoms are more marked; treatment is the same.

Of other gases used, none is harmful to the eye. The lacrimators cause a transitory congestion, lacrimation, blepharospasm, and burning sensation. Symptoms cease shortly after removal of contaminated atmosphere.

SUMMARY

In conclusion, the salient points in the treatment of war gas injuries of the eye may be summarized: Prophylaxis includes use of the gas mask and periodic eye irrigation. Immediately after exposure, lavage may decrease the possible extent of an imminent lesion. Repeated irrigation insures against bacterial complications. The eyes should be opened to release imprisoned tears, and to demonstrate to the patient that vision is not lost. A shade or dark goggles rather than a bandage should be used for protection against light. Mineral oil is instilled to prevent adhesion of raw surfaces. Atropine is used in eyes with corneal damage.

820 Professional Building.

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NEW ADRENALIN-LIKE COMPOUNDS: THEIR ACTION AND THERAPEUTIC APPLICATION*

M. H. NATHANSON, M. D.
Los Angeles

IN 1895, Oliver and Schafer first demonstrated that extracts of the adrenal medulla produced marked rises in blood pressure in experimental animals. This led to the belief that the adrenal glands secreted a hormone which affected vascular tone, and many attempts were soon made to isolate this hormone. The investigations of v. Fuerth (1898) and of Abel (1897-1899) resulted in the isolation by Takamine (1901) and by Aldrich (1901) of adrenalin in crystalline form. Its chemical structure was elucidated by Jowett in 1904, and its synthesis accomplished independently by Stolz in 1904, and by Dakin in 1905. Soon many investigators were studying the action of compounds related in chemical structure to adrenalin. The most extensive study was carried out by Barger and Dale in 1910. They studied a very large number of compounds, and showed that universal sympathetic stimulation is not peculiar to adrenalin but may be produced by a large number of related amines. They demonstrated the relative importance of the various groups in the adrenalin molecule on the physiological action of the drug. They introduced the term "sympathomimetic," to describe the action of the group as a whole, and concluded that the intensity and specificity of action increases as the chemical structure of the compound approaches that of adrenalin. In spite of this study, and others in which large numbers of sympathomimetic compounds have been investigated, no advance of practical importance was made until the introduction in this country in 1923 of ephedrine. The addition of ephedrine permitted the use of a sympathomimetic substance which was effective when administered by mouth, and broadened the therapeutic scope of this group of compounds appreciatively. In spite of further work in this field, and the in-

troduction by pharmaceutical houses of adrenalin substitutes, no new compounds of definite therapeutic value were developed. This is demonstrated by the fact that in the 1937 edition of the excellent and comprehensive *Manual of Pharmacology* by Sollmann, six adrenalin-like compounds are discussed, only two of which have any therapeutic value, adrenalin and ephedrine. In the last five years two new compounds have been added, which appear to have real therapeutic value and have increased definitely the therapeutic application of the sympathomimetic drugs. These new substances are paredrine (parahydroxyphenylisopropylamine) and benzedrine or amphetamine* (phenylisopropylamine).

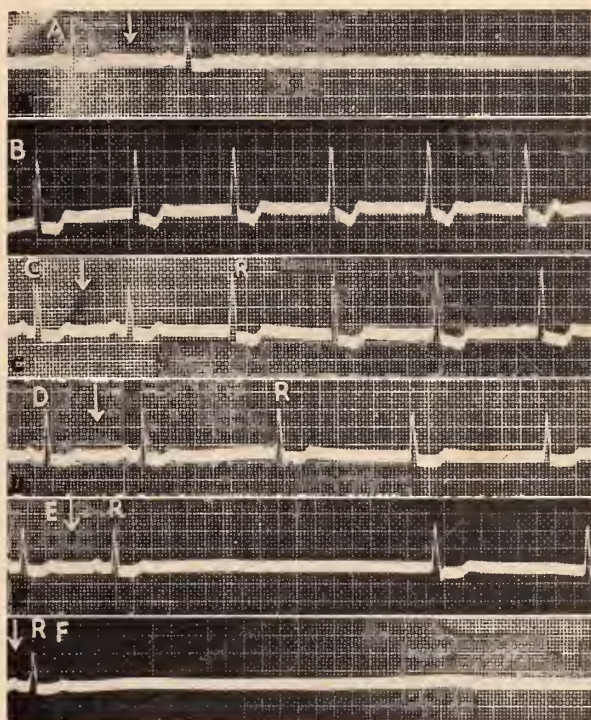


Fig. 1.—A. Electrocardiogram showing a cardiac standstill of 7.6 seconds induced by pressure on the right carotid sinus (arrow). Lower strips taken after the intravenous injection of 1/20th mgm. of adrenalin. Pressure now on carotid sinus results in a ventricular rhythm, rate 60. F shows the disappearance of the effect, 15 minutes after the injection of the drug.

PAREDRIENE

Cardiac Action.—Paredrine has been found by Alles,¹ and by Alles and Prinzmetal² to be a stable and potent sympathomimetic substance. The writer became interested in this compound during his studies on the action of drugs on induced cardiac standstill in man.³ Prior to these investigations, the response of the blood pressure in the experimental animal had been used almost

* From the Department of Medicine, University of Southern California.

Read before the Section on Medicine, at the 70th Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

* Amphetamine is the name which has been applied in 1937 by the Council on Pharmacy and Chemistry. In this paper, the name benzedrine is used, as it is still the more familiar name for the drug.

exclusively as the index of the comparative activities of the sympathomimetic amines.

The method of induced cardiac standstill has the advantage of being applicable to man, and permits a pharmacological investigation in the human subject under controlled conditions. The

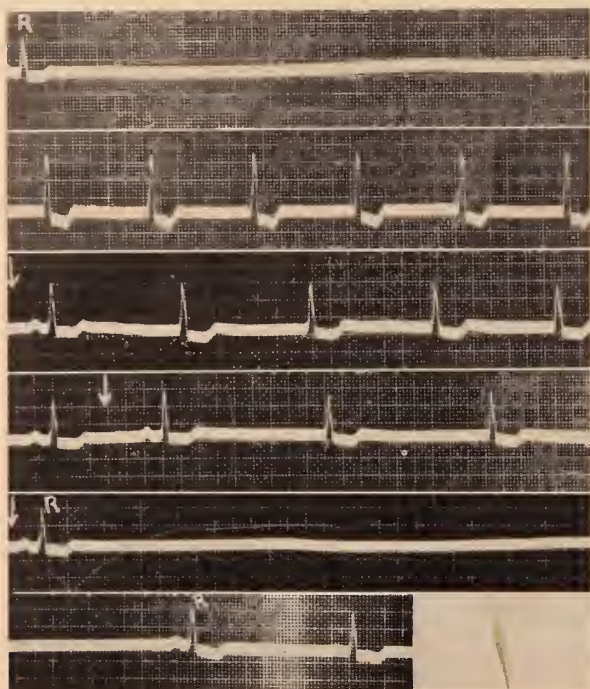


Fig. 2.—Upper strip shows standstill of 11.8 seconds induced by pressure on the carotid sinus. Lower strips show the effect following the intravenous administration of 100 mgm. ephedrine. The reaction resembles that of Fig. 1, giving a ratio of activity of ephedrine to adrenalin of 1:2000.

method depends on the fact that, in many human subjects, especially elderly males, it is possible to produce repeatedly a standstill of the heart of many seconds duration by digital compression of a specialized portion of the carotid artery in the neck, called the carotid sinus. This produces a reflex stimulation of the cardiac vagus nerve with inhibition of the cardiac pacemaker, the sinus node.

The technique of the experiments is very simple. In a susceptible subject an electrocardiogram is made showing the standstill produced by pressure on the carotid sinus. The drug to be tested is then administered and the experiment repeated after a suitable interval. It was found that all of the sympathomimetic amines tested abolished the standstill in varying doses chiefly by initiating a new pacemaker in the ventricle. The rate of the new pacemaker was proportional to the dose of the drug. It was possible to compare the relative activities of various sympathomimetic amines by this method. The reaction to natural adrenalin was used as a standard and the response to varying doses of adrenalin was first determined. The reaction of

other sympathomimetic amines was then compared with that of adrenalin, and an approximate ratio of activity established. For example, an intravenous injection of 100 mgm. of ephedrine in one subject reproduced the effect of 1/20th mgm. of adrenalin giving a ratio of activity of ephedrine to adrenalin of 1 to 2000 (Fig. 1 and Fig. 2). Of a large number of sympathomimetic amines studied by this method, the comparative activities on cardiac standstill of the more important are indicated in:

TABLE 1.—Comparative Activities on Cardiac Standstill.

Drug	Approximate Ratio of Activity to Adrenalin
Cobefrine	1:10
Neosynephrin	1:100
Synephrin	1:400
Paredrine	1:500
Ephedrine	1:1500
Benzedrine	1:1500

The results of our studies by the method of induced cardiac standstill led to the following conclusions: (1) the only substances which are effective in the treatment or prevention of cardiac standstill are the adrenalin-like compounds, as no compound unrelated to adrenalin is found to have any action; (2) the most effective substance is adrenalin and the most active stable compound, one having a prolonged action and effective on oral administration is paredrine.

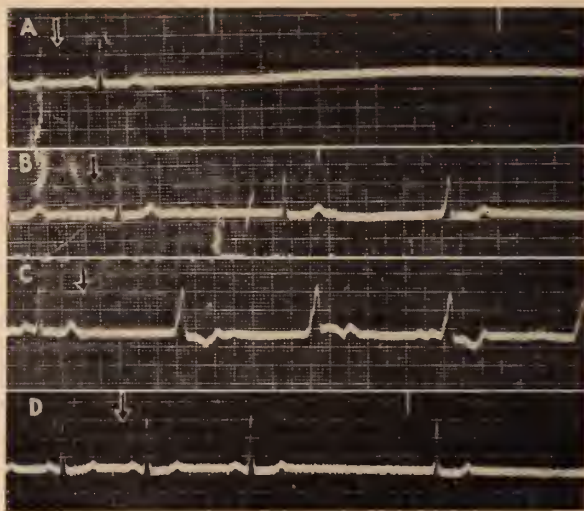


Fig. 3.—A shows a standstill of 5.2 seconds induced by pressure on the right carotid sinus (arrow). B taken 30 minutes, C, 1 hour and D, 2 hours and 20 minutes after the administration of 60 mgm. paredrine by mouth. In this patient, syncopal attacks could be prevented by 60 mgm. paredrine hydrobromide three times a day by mouth.

Practical Application.—The two most common conditions in which syncope due to cardiac standstill occur are (1) the ventricular standstill associated with heart block and, (2) the cardiac arrest associated with a hypersensitive carotid sinus.

In cases of heart block in which attacks of syncope are frequent, adrenalin is still the drug of choice, and a subcutaneous injection every three to four hours should increase ventricular irritability sufficiently to prevent ventricular standstill. In cases of chronic heart block, with

son was made of the effect of paredrine and ephedrine, and ephedrine was found to be $\frac{1}{3}$ to $\frac{1}{2}$ as effective as paredrine. Of special interest in the case of paredrine was the fact that symptoms referable to nervous stimulation, such as nervousness, tremor or apprehension, were not observed.

Pressor Action.—More recently the writer, in association with Dr. Hyman Engelberg, has studied the pressor action of paredrine. The details of these studies are published elsewhere. The administration of paredrine produces a definite and sustained rise of arterial pressure when administered by mouth, subcutaneously or intravenously. On oral administration of 40 mgm., the pressor effect is observed in 15 minutes in most instances, and the maximum effect occurs in 30 to 60 minutes. The duration of the pressor action with a 40 mgm. dose varies from 60 to 90 minutes. Figure 4 shows the blood pressure responses of 3 individuals receiving 40 mgm. paredrine hydrobromide by mouth. Following a subcutaneous injection of 20 mgm. the onset of the effect is within 5 to 10 minutes, and the maximum effect is usually in about 1 hour. The systolic pressure is affected much more than the diastolic pressure. There is considerable variation in response in different individuals to a given dose.

The clinical application of the pressor action of paredrine is the subject of further study. In Germany, a related compound, the *n*-methyl derivative of paredrine, has received a great deal of attention under the trade name of "Veritol." This drug has been recommended as a



Fig. 4.—Blood pressure reactions in three normal individuals following the oral administration of paredrine hydrobromide, 40 mgm.

infrequent syncopal attacks, a drug effective on oral administration is very desirable. A dose of 40 to 60 mgm. of paredrine, three or four times a day, appears to be sufficient to lessen definitely the tendency to cardiac standstill. This applies also to the syncope associated with a hyperactive carotid sinus. There is a great variation in response in different individuals, and failure to lessen the frequency of attacks may be due to insufficient dosage. In several instances in which the course was not definitely modified by doses of 60 mgm., a definite effect was obtained when the dose was increased to 80 mgm.

The effect of paredrine has been studied in 16 individuals in whom cardiac standstill could be produced by pressure on the carotid sinus⁴ and in all of these the standstill could be abolished by the drug. (Fig. 3.) Six individuals had spontaneous attacks of syncope, and, in four cases which have been followed for a considerable period, the drug has lessened the number or eliminated the attacks. In four cases, a compari-

		Peripheral Action	Central Action
Adrenaline	<chem>OCC1CCC(O)CC1</chem> <chem>CHOH-CH2-NHCH3</chem>	++++	+
Ephedrine	<chem>CC1CCC(CC1)N</chem> <chem>CHOH-CHCH3-NHCH3</chem>	++	++
Benzedrine	<chem>CC1CCC(CC1)N</chem> <chem>CH2-CHCH3-NH2</chem>	++	++++
Paredrine	<chem>OCC1CCC(CC1)N</chem> <chem>CH2-CHCH3-NH2</chem>	++++	—

Fig. 5.—Structural formulae and relative peripheral and central activities of four sympathomimetic amines.

superior agent in the treatment of shock. Studies carried out in association with Dr. Engelberg have shown that paredrine is definitely a more effective pressor substance than Veritol, or paredrinol as the drug is called in this country. The

writer has administered paredrine to a miscellaneous group of individuals in shock, with a prompt and sustained rise of blood pressure in most instances. It will require the careful study of a large group to determine the therapeutic value of this drug in shock. Altschule and Gilman⁵ found that paredrine was useful in raising the blood pressure to satisfactory levels if it becomes unduly lowered in spinal anaesthesia. Hersh,⁶ in more than 200 cases of spinal anaesthesia, found that the preanaesthesia administration of paredrine effectively prevented a fall in arterial pressure.

Mydriatic Effect.—Brief mention should be made of the mydriatic action of paredrine, as the few available reports indicate that it is the most effective of the sympathomimetic amines in this action, and closely approaches the ideal mydriatic. Complete dilatation of the pupils follows the application of a one per cent solution in 45 minutes, the effect lasting 2 hours. There is little or no effect on accommodation or intraocular tension.

BENZEDRINE

Central Action.—As has been indicated, investigations on the sympathomimetic amines have centered almost entirely on the action on the sympathetic nervous system. There are observations, however, which demonstrate that certain of these compounds produce also, in addition to their sympathomimetic action, a stimulation of the central nervous system. The exact site of this action is not at present clear. Prior to the introduction of benzedrine, observations had been made on ephedrine which indicated this central nervous stimulation. Experimentally, as early as 1913⁷ it was shown that narcotized animals could be awakened by ephedrine. This drug has also been used as an antidote for narcotic drugs in patients.⁸ Schmidt⁹ reported a stimulation of the respiratory center by ephedrine. Raginsky and Bourne¹⁰ reported that ephedrine could shorten or interrupt avertin anaesthesia in dogs and man. In therapeutics, the central effect of ephedrine is usually an undesirable action, since it is the cause of the unpleasant side effects such as nervousness, tremor, insomnia, nausea and sweating. The central stimulation has been utilized, however, in the treatment of narcolepsy, and good results reported.¹¹ Alles¹ observed that benzedrine produced a waking effect in his experimental animals. Prinzmetal and Bloomberg¹² were the first to use benzedrine in the treatment of narcolepsy, and they concluded that it was approximately three times as effective as ephedrine. Shortly after this report appeared, the writer felt that the drug might have a wider application for the following reason: typical narcolepsy is a relatively rare condition, but symptoms of a milder degree, resembling those of narcolepsy, are extremely common. The two chief features of narcolepsy are (1) attacks of somnolence and (2) paroxysms of extreme mus-

cular weakness (cataplexy). The exact nature of narcolepsy is unknown, but it has been suggested that the condition may merely represent an exaggeration of the frequently observed fatigue and exhaustion of unknown or indefinite origin.¹³ For this reason, the drug was studied in a group of individuals complaining of chronic exhaustion, and in approximately 80 per cent there was a marked amelioration of this symptom. Certain other reactions were observed, and this led to the study of the subjective reactions of a large group of normal subjects following the administration of the drug.¹⁴ A control group of 25 subjects received lactose tablets and the reactions of the two groups compared. Table 1 summarizes the reactions of the group receiving benzedrine. This study was carried out in 1936, and since that time a large literature has accumulated, and these effects have been confirmed and many applications to therapy have been suggested. The great interest in this compound is illustrated by the fact that, with the exception of the sulfonamide group, benzedrine has received more attention than any other recently-developed drug. The drug has been suggested in the therapy of such a large and unrelated group of conditions that one might expect some skepticism as to its efficacy. However, in most cases, the suggested clinical uses have been confirmed by many observers, and also in practically every instance the drug has been recommended as a more or less important adjunct to other forms of treatment. The list under Table 2 includes most of the conditions in which benzedrine has been suggested:

TABLE 2.—List of Conditions in Which Benzedrine Has Been Indicated.

Narcolepsy.
 Chronic exhaustion and miscellaneous asthenic states.
 For increase of mental and physical energy in normal individuals.
 Mental depressions.
 Obesity.
 Alcoholism, acute and chronic.
 Morphine addiction.
 Barbiturate intoxication and narcosis.
 Post-encephalitic Parkinsonism.
 Epilepsy—with phenobarbital or dilantin.
 Migraine.
 Myasthenia—with prostigmine.
 Postural hypotension.
 Seasickness.
 Hiccough.
 Eneuresis.
 Dysmenorrhea.
 Spastic conditions of gastro-intestinal tract.

Space will not permit a detailed discussion of these therapeutic applications. However, the more important clinical uses will be mentioned briefly.

Narcolepsy.—The observations of Prinzmetal and Bloomberg¹² have been repeatedly confirmed, and in this condition there is no other drug which approaches the effectiveness of benzedrine. The drug must be given in relatively large doses (30-50 mgm. a day). Benzedrine produces striking symptomatic relief, but is not a cure of narcolepsy, so that usually the treat-

ment must be continued indefinitely.

Bloomberg¹⁵ reports on 3 patients who have been taking 70 mgm. or more a day, two of them for 2 years and 8 months, and one for a year and 8 months. The drug continues to be effective and no harmful effects were noted.

Chronic Exhaustion.—Lack of energy and easy fatigue are among the most frequent complaints encountered by the physician. There is usually no organic basis for this symptom, and most cases can be included under the term nervous exhaustion. As indicated above, many of these individuals may be considered as suffering from a mild form of narcolepsy. In about 80 per cent, the symptomatic relief after the administration of benzedrine is about as striking as in true narcolepsy. It must be emphasized that the treatment is entirely symptomatic, and should be used only in conjunction with other corrective methods. The usual dose is 5 to 10 mgm., taken morning and noon. If taken late in the day, there will frequently be a disturbance in sleep.

Application in Normal Individuals.—In the study on normal individuals carried out in 1936,¹⁴ the increase in mental and physical activity was so striking, in many instances, that it was suggested that the drug might serve a useful purpose in preparing an individual for situations which require the expenditure of special amounts of physical or mental energy. Various studies indicate that benzedrine increases the intelligence score under test conditions, and that psychomotor skill is increased. It is true that the improper use of the drug for this purpose has led to considerable publicity, and much warning as to possible harmful effects. The widespread and indiscriminate use by students in preparation for examinations is an illustration of improper usage. However, when intelligently used, the drug has a place in the preparation of an individual for an exceptionally difficult situation. The effect is usually noticed within from 30 to 60 minutes after administration of a single dose of the drug.

Mental Depression.—As pointed out in the earlier study, one of the striking and consistent effects of benzedrine is a sense of well-being and feeling of exhilaration. This modification of the mood has been extensively studied. The interest in the psychic effects of benzedrine is illustrated by the fact that an increasing number of the publications are to be found in journals of psychiatry or psychology. Davidoff and Reifstein¹⁶ concluded that the drug was more valuable in certain of the organic psychoses than in psychoneuroses. They feel that benzedrine is especially valuable in the psychoses associated with alcoholism, and to some extent in the psychoses due to infection or trauma. From my own observations the drug has been of particular value in the treatment of psychoneuroses associated with asthenia and mild melancholia. In serious depressions, especially those accompanied

by anxiety or mania, most investigators report either negative or unfavorable results. I have seen definite improvement in mood in cases of melancholia and self-absorption associated with cerebral arteriosclerosis. Elderly individuals, in most instances, tolerate the drug well. The drug also has a favorable influence on the asthenia and depression associated with the menstrual period.

Obesity.—One of the most striking effects noted in our earlier report¹⁴ was the tendency of benzedrine to reduce appetite and cause a loss of weight. This was manifested by either a diminution in the desire for food or by the satisfaction of the appetite by a reduced amount of food. The drug is quite unique in this action, as there is certainly no other substance which has such a specific effect on appetite in therapeutic doses. In many instances obesity is due to a perversion of the appetite. The normal satisfaction from food is impaired, and frequent eating and craving for food follows. It is difficult for such individuals to follow a low calorie diet. In such cases, particularly, benzedrine has its most striking effect. The writer has had the opportunity of comparing the results of a low calorie diet with, and without, benzedrine in a number of obese individuals. In each instance, the addition of benzedrine was followed by a greater loss of weight, and in some cases an appreciable loss of weight could be attained only by the administration of the drug. It is frequently possible to discontinue the drug after proper eating habits have been established. Another factor in the weight-reducing effect of benzedrine is the increased physical activity induced by the drug. This is especially the case in sluggish and inactive individuals.

Peripheral Action.—Since benzedrine is a sympathomimetic amine, it will exhibit in the various organs, its sympathomimetic action in proper dosage. Thus the pupil is dilated, the bronchi relaxed, the blood pressure raised and cardiac standstill prevented. The effect on the smooth muscle of the gastrointestinal tract is variable. The drug therefore, has been recommended in asthma, in hypotensive states and for the prevention of carotid sinus syncope. It has also been suggested in spastic gastro-intestinal conditions and as an aid in gastro-intestinal roentgenology because of its relaxing effects on smooth muscle. In this, there has been much difference of opinion as to the efficacy of the drug. The therapeutic application of benzedrine for its sympathomimetic action appears unjustifiable. The drug is unique in its powerful central effect, and is the best example of a sympathomimetic drug with a strong central action and comparatively weak peripheral effect. Figure 5 represents the comparative peripheral and central actions of four of the important amines. The central action results from doses of benzedrine considerably below those which induce a sympathomimetic response, so that it is very unlikely that a peripheral action can be produced

without an overstimulation of the central nervous system. Benzedrine is of definite value in orthostatic or postural hypotension. The drug, however, may produce symptomatic relief without influencing the postural effect on the blood pressure. It is probable, therefore, that the drug exerts its effect in this condition through its central action. In two of three cases of postural hypotension, I have found that the combination of benzedrine and paredrine was superior to benzedrine alone. This has also been observed by Korns and Randall.¹⁷ The chief uses of the peripheral action are for local application to the congested nasal mucosa and for the mydriatic effect.

Variations in Effect.—There is considerable variation in the response of different individuals to the drug. Although 5 to 10 mgm. is the average dose, and this is well tolerated, some individuals require 20 to 30 mgm. for a therapeutic effect, and others develop unpleasant reactions from doses as small as 2½ mgm. A striking variation in the response is that some individuals develop drowsiness instead of a stimulating effect. In Table 1, it will be noted that benzedrine produced depression in 7 per cent of the group. It is clear, therefore, that the drug is not applicable to all individuals, as some develop unpleasant reactions in doses below the usual effective dose and others do not obtain the desired stimulating effect.

Unpleasant Reactions and Toxicity.—As was pointed out in the earlier report¹⁴ unpleasant reactions are not uncommon, but are usually transient and rarely severe. Dryness of the mouth, an unpleasant taste, sweating, insomnia, tremor of the hands, palpitation, nervousness, tenseness, are the usual unpleasant reactions which may require discontinuance of the drug or reduction in dosage. These unpleasant reactions must be differentiated from true toxic effects. The actual toxicity of the drug is very low. The minimum lethal dose varies in different animals, but the average acute lethal dose by injection appears to be 20 to 30 mgm. per kilogram weight. The low toxicity is apparent when one considers that a dose of 10 to 20 mgm. has a definite effect in most individuals. In five years of rather extensive experience with the drug, I have seen no instance of a true toxic effect. Several cases of collapse have been reported, but there is a question as to what extent the drug was implicated in these reactions. There are reports of gross over-dosage which indicate the low toxicity of the drug. Accidentally, or with suicidal intent, amounts of 125 to 500 mgm. have been taken without a lethal effect. I am familiar with one instance in which 20 or 30 tablets (200 to 300 mgm.) were taken at one dose. The patient, after a period of excitability, recovered within a few days. The drug is rapidly absorbed and excreted, and there has been no indication of cumulative effects. The unfavorable publicity because of indiscriminate use has probably been beneficial in discouraging

the abuse of the drug by the laity, but has also left many with an incorrect impression as to the actual toxicity. Benzedrine is a potent drug, having a powerful stimulating action and, therefore, should be used with discrimination. A possibility of a harmful effect does exist in that prolonged administration may lead to increased activity and energy expenditure beyond the capacity of some individuals. This is especially possible since the protective and retarding influence of fatigue is lost. Judgment in the administration of the drug should effectively prevent this, but it is possible that such a harmful effect may occur in individuals who are taking the drug without a physician's guidance.

CONCLUSIONS

Paredrine and benzedrine, two new and closely-related adrenalin-like compounds, possess certain features which make them of value in therapeutics.

Both are stable compounds, having a prolonged action, and are effective on oral administration.

Paredrine has an active cardio-vascular effect and is useful in the prevention of cardiac or ventricular standstill.

Benzedrine is the most powerful central nervous stimulant of the adrenalin-like compounds, and is of therapeutic value in a variety of clinical conditions.

The addition of these compounds broadens the therapeutic scope of the sympathomimetic amines.

658 South Bonnie Brae

TABLE 1.—Reactions of 55 Members of a Resident Hospital Staff and Laboratory Technicians After the Oral Administration of 20 mgm. of Benzedrine Sulphate. (Reprinted by Permission from the Journal of the American Medical Association)

	Number	Per Cent
Increased energy, desire and capacity for work	30	54.5
Reaction to work as regards fatigue		
(a) Less fatigue	34	62.0
(b) Increased fatigue	10	18.0
(c) No effect	11	20.0
Usual period of exhaustion abolished.....	21	38.0
More talkative	31	56.0
Euphoria and feeling of exhilaration.....	37	67.0
Depression	4	7.0
Mental activity and efficiency		
(a) Increased	23	42.0
(b) Diminished	2	3.6
Dryness of mouth.....	34	62.0
Sweating	27	50.0
Appetite		
(a) Less	27	50.0
(b) Better	5	9.0
Insomnia (usually mild to moderate).....	17	30.0

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THYROID IN PREGNANCY*

CONRAD J. BAUMGARTNER, M.D.
Los Angeles

WOMAN in the pregnant state demands considerable activity on the part of her complex endocrine system. It has long been known that the thyroid frequently is enlarged at menstruation and during pregnancy. That there is an actual hyperfunction of the thyroid gland of the mother during pregnancy was recently demonstrated by Soule¹ who found that a substance is present in the blood serum of pregnant women, which lowers the level of mouse-liver glycogen; which reduction indicates an increased level of thyroid hormone. Various observers have estimated the accompanying increase in the rate of metabolism to be from 15 to 25 per cent. The curve ascends slowly until about the sixth month of pregnancy, and thereafter rises more abruptly.

In spite of this increased response of the thyroid to demands of maternal and fetal tissue, true hyperthyroidism is probably never caused by pregnancy, and is not commonly associated with pregnancy. Mussey² of the Mayo Clinic stated that exophthalmic goiter is not encountered more than once or twice in 1000 cases of pregnancy in that area, and reported 41 cases of hyperthyroidism occurring over a period of seven years. In the same period of years, Janert³ reported 18 cases of hyperthyroidism with pregnancy, observed at the Women's Clinic of the New York Hospital, in a total of 23,439 patients; an incidence of only .076 per cent. Wallace⁴ found a similar ratio of 9 cases in 11,571 patients

admitted to a Brooklyn hospital, while Markee⁵ of New York could find only 8 cases of hyperthyroidism with pregnancy in 100,000 admissions. Higher incidences, however, are reported from some of the goiter belt cities. Portis and Roth,⁶ found a 1.4 per cent incidence in Chicago, but this was only taking 1000 cases. From Detroit there is a report by Yoakum⁷ of a 3.7 per cent incidence. At the Lahey Clinic,⁸ out of 3678 consecutive goiter operations, there were only 15 who also were pregnant.

I have recently reviewed 1585 histories of goiter patients admitted to the Los Angeles General Hospital from 1930 to 1940. The diagnosis of coincident nontoxic goiter with pregnancy was given in 19. There were 28 in whom a diagnosis was made of hyperthyroidism with pregnancy. In six of these, the findings were insufficient to be certain of the diagnosis, leaving 22 proven cases. During this same period, the Los Angeles General Hospital admitted 39,419 women who were pregnant, giving an incidence of about .05 per cent of hyperthyroidism in pregnancy, roughly about 1 to 2000.

With but one exception, no treatment was carried out in any of the nontoxic goiters. This one exception was a patient, eight months pregnant, who had to have a thyroidectomy performed because of a huge nodular goiter which was causing grave obstructive dyspnea. She had immediate relief after surgery, and went into labor the same day without further trouble.

Of the 22, five had adenomatous or nodular goiters with an average age of 33 years. The remaining 17 had exophthalmic or diffuse toxic goiters, with an average of 29 years, and of these five, or 30 per cent, were in recurrent exophthalmic goiters. This is certainly a strikingly high percentage of recurrent goiters and would tend to refute the commonly-accepted idea that hyperthyroid patients do not become pregnant. In Lahey's⁸ series there were 13 with exophthalmic goiter and two with toxic adenomas, while in Mussey's² series there were 29 cases of exophthalmic goiter and 12 of adenomatous goiter.

There is still considerable variation of opinion, not only in this hospital but in others as well, as to what is the course to be advised to the pregnant woman who also has a proven hyperthyroidism. To demonstrate this variation of opinion, I would like to narrate verbatim the notes of the various consultants on one specific case.

REPORT OF CASE

Mrs. R. D., age 26, who had one baby 14 months before, entered the hospital, June, 1932. She complained of nervousness, rapid heart and loss of weight, and felt she might be pregnant, having menstruated last in March, 1932. She had a pulse of 120. The thyroid was enlarged to three times its normal size. She had an exophthalmos and tremor, and the basal metabolic rate was plus 54. She was found to be three months pregnant. Here is what the different consultants had to say:

Consultant No. 1:

"Diffuse hypertrophy of thyroid, probably pregnant. therapeutic abortion would be advisable thing; and then

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From the Departments of Surgery, Los Angeles General Hospital and the College of Medical Evangelists.

take care of thyroid in 10 days or 2 weeks, depending on the patient's condition."

Consultant No. 2:

"Personally, I see no indication for preceding thyroidectomy with abortion. Occasionally, such procedure precipitates crisis, and early in pregnancy, before five months, pregnancy does not add to thyroid toxicity. Spontaneous abortion following thyroidectomy is not common. Tachycardia is, and will persist after abortion."

Consultant No. 3:

"It would be much safer in my opinion to abort the patient expecting some thyroid reaction following, than to remove the thyroid expecting a reaction, with added load of pregnancy."

Consultant No. 4:

"Treat thyroid as indicated. Nothing to be gained by abortion. Review of literature of Mayo, Lahey and other clinics shows that thyroidectomy is operation of choice in these cases, and that pregnancy may be disregarded. Believe thyroidectomy should be done before escape period sets in."

Fortunately in spite of such divergence of opinions among her consultants, this lady finally had a thyroidectomy performed. She made an uneventful recovery, and delivered a healthy baby in December, 1932.

THERAPEUTIC ABORTION

There are those who do favor early therapeutic abortion. At the New York Hospital Women's Clinic,³ 2.34 per cent of all abortions were for hyperthyroidism, and in no case was thyroidectomy performed. That the thyrotoxicosis, and not the pregnancy should be interrupted, is however, the opinion of the greatest number, among whom are Mussey,² Means, Frazier,⁹ Bothe,¹⁰ Lahey,⁸ and many others. At the Los Angeles General Hospital there were, fortunately, no therapeutic abortions for hyperthyroidism.

COMMENT

Of the five toxic nodular goiters in this study, one had a spontaneous abortion, and one had a hysterectomy of a large fibroid containing a 12 cm. fetus. Another had a spontaneous, eight-months' premature delivery shortly after entrance; one had a thyroidectomy but aborted six weeks later which, therefore, could not have been attributed to the thyroidectomy; and another, admitted at eight months, fibrillating with a heart rate of 160 and a blood pressure of 190, had a quick low Caesarian with normal convalescence, and three months later, thyroidectomy.

As mentioned, five or 30 per cent of diffuse or exophthalmic goiters were in recurrent goiters. The general trend of their management differed so greatly that each should be considered separately. Of the recurrent group, all but one were seen between the second and fourth months of pregnancy, and one at seven months. Thyroidectomy was performed but once and that, in a three months' pregnancy. In another, at two months, surgery was advised but refused, and x-ray therapy was instituted. One was given x-ray therapy in her fourth month, but a follow-up was not

possible, and the remaining two were carried along on Lugol's alone. All went to full-term delivery. One receiving x-ray, not being followed to term, wrote in that she was no better. It appears that surgeons are a little bit more hesitant in these recurrent cases.

Of the twelve exophthalmic goiters, seven were admitted in the first trimester. Of these, four had partial thyroidectomy and three were carried along on Lugol's and medical management. Two were not heard from, while the rest all went to full term delivery. There were no operative mortalities. Five exophthalmic goiters were admitted in the seventh or eighth month of pregnancy. These, in the last trimester, were all placed on Lugol's, but only one went on to full-term delivery. All the remaining four had premature deliveries, one had a dead, macerated, seven-month fetus.

DISCUSSION

It is quite obvious from this survey that confusion still exists, and that an attempt should be made to get at least some uniformity of opinion as to what procedure should be carried out in the frank hyperthyroid who is also pregnant.

It has been shown that patients who give some evidence of hyperactivity do better on small doses of iodine during pregnancy. Carl Davis¹⁴ advocates iodine routinely to all pregnant women in goiter belts, and he gives it in the form of one iodostearin tablet every other day, or five drops of Syrup of Hydriodic Acid every other day.

In the mildly toxic cases, medical treatment as advised by Bothe,¹⁰ Mussey² and others may be instituted. The patients are placed in bed, given sedatives and Lugol's solution M 10 three times daily after meals, preferably in milk or grape juice. In such cases, however, distinct improvement to normal or near-normal must be reached within two weeks, when it may be decided to carry the patient through pregnancy with iodine. If near or complete remission is *not* obtained within two weeks, partial thyroidectomy should be performed. In these milder cases, medically treated, one must always be mindful of a possibly false sense of security which the first dramatic improvement may produce, only to be followed by a recurrence of symptoms at a later date when surgery might have to be performed at a less favorable period of pregnancy.

Of the frank thyrotoxic case, the words of Lahey are wisdom. He states: "We strongly urge that the association of pregnancy with thyrotoxicosis is distinctly a mortality factor when pregnancy is permitted to advance to the later stages, and that this mortality factor can be avoided without undue risk to mother or pregnancy by early subtotal thyroidectomy." Thyroidectomy in the first trimester does not cause abortion. In Lahey's series the only mother who miscarried, did so after a long automobile ride home from the hospital; and in Mussey's series, there were no miscarriages. The advocates of early interruption

of pregnancy must realize that it leaves the patient *still* with her hyperthyroidism, and that in the presence of hyperthyroidism even a *minor* surgical procedure may throw the patient into a severe crisis.

In the rare case which does not respond to Lugol's solution for preoperative preparation, and in which surgery is considered too great a hazard, one might resort to x-ray therapy. The Hertzler group, of V. E. Chesky, C. R. Schmidt, and W. R. Walsh,¹² has recently done some remarkable work on liver function tests in these cases, and have found alarmingly low liver function in most hyperthyroid states, which can and must be improved by proper glucose replenishment in all of those cases, whether surgery is attempted or not.

The patient who has proceeded into the last trimester with marked hyperthyroidism presents a real problem. The majority will go into premature labor as shown in other series as well as in our own. Mussey² states: "Except in selected cases in the last trimester of pregnancy, partial thyroidectomy should be performed if the exophthalmic goiter does not give evidence of complete or nearly complete remission within two weeks after treatment with iodine has begun." Lahey, in his "Surgical Practice" recently published, states: "There need be little change in management of the hyperthyroidism complicated by pregnancy. Operation is advised and carried out up to and including the eighth month." As pregnancy approaches term, one may have reasonable doubt as to what might be the safest procedure. In one very desperate case in this series, a happy result was obtained by a section performed with dispatch. Thyroidectomy at *this* stage almost invariably starts immediate labor process, and one might weigh carefully whether the shock of surgery and delivery all in the period of a day might not prove too much. At this critical period, one might well consider Lugolization and rapid Caesarian rather than prolonged labor.

HYPOTHYROIDISM

The possible rôle of hypothyroidism as a causative factor in amenorrhea, menorrhagia, abortion, miscarriage, premature labor, and death of the fetus has been referred to by Breckenridge,¹³ Davis,¹¹ Frazier and Ulrich,⁹ Litzenberg and Carey,¹⁵ and others. Its possible rôle in relationship to toxemia of pregnancy has been pointed out by Hughes,¹⁶ who advises administration of iodine early in pregnancy to those patients who have low metabolic rates. It is his contention that he thereby can reduce the incidence of toxemia later in pregnancy. Although the incidence of sterility is high among hypothyroid women, the fact remains that they do become pregnant.

Myxedema, with its classical thickened skin and fluid retention, should be easily recognized, but other symptoms of hypothyroidism, such as drowsiness, fatigue, joint pains, mental depression, constipation and falling hair might easily be

overlooked. In the opinion of Carl Davis,¹¹ practically all individuals who have a dry skin, slow pulse and a subnormal temperature, have a low metabolic rate. In a series of six hundred consecutive basal metabolic readings in women, he found about 10 per cent with metabolic rates lower than minus 20 to 25, and in his opinion the infants of these women will show a deficiency of thyroid, unless the mothers are given prophylactic doses of thyroid and iodine during pregnancy.

PREVENTION OF GOITER

A presentation of "Thyroid in Pregnancy" would not be complete without mention of something which most obstetricians do not consider in their realm at all, and which they usually relegate into the hands of the pediatrician, namely, that of the *prevention* of goiter. Marine and Kimball,¹⁸ through their epochal work have made those men who take care of children and adolescents, particularly in the goiter belts, very conscious of their duties in the prevention of goiter, and it is almost a universally accepted fact from this work that if the adolescent is given small doses of iodine, endemic goiter can and will be prevented in most cases.

The prevention of goiter goes back even farther, as has been shown by Eggenberger,¹⁷ of Switzerland. He took a large series of pregnant women in one of their large hospitals and gave them all iodine throughout pregnancy. Owing to the use of iodized salt by the prospective mothers from the beginning of pregnancy, in 2,000 cases, no babies were born with goiter. In those cases in whom iodine was not administered, about 50 per cent of the new-born babies showed thyroid enlargement, and 100 per cent epithelial hyperplasia and deficiency of colloid substance in the thyroid gland. Goiter in puberty did not appear in children who used iodized salt from the time of birth. It is evident that the obstetrician and those who do *obstetrics*, particularly in the goiter belts, can play a much greater rôle in the prevention of goiter before birth, than can the pediatrician after birth, by administering iodine routinely to their pregnant women.

523 West Sixth Street.

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TUMORS OF THE RECTUM*

KENNETH E. SMILEY, M. D.
Los Angeles

TUMORS of the rectum comprise a very large and varied group, and it is not the purpose of this paper to present in outline the various types, but rather to limit the discussion to the polyps or polypoid types of tumors, and especially those that afford evidence of questionable or very frank malignancy.

With rare exceptions these consist of three groups: the benign and malignant adenomas, the villous papillomas, and the carcinomas resembling either the sessile adenoma or, more rarely, the papilloma. The adenomas are true mucosal tumors, and vary in size from tiny, flat, almost invisible growths to tumors of several centimeters in diameter. When small they are sessile, but as they enlarge a pedicle of normal mucosa may or may not be formed by the constant tug on the bowel wall. Histologically, they resemble normal mucosa, except that the glandular structures are more elongated and variable in size. The villous papillomas are soft and sponge-like in appearance and on palpation, usually have a wide base, and may reach a size which fills the ampulla of the rectum.

* Read before the Section on General Surgery at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

BENIGN AND OTHER LESIONS

There has been considerable discussion as to the relationship of the benign rectal polyp to carcinoma of the rectum, and at present it is generally believed that many, if not all of these tumors are definitely premalignant, although it is rare to find high-grade malignancies arising in polyps. Carcinoma of low grade not infrequently may be found in the most innocent-appearing polyps. Of considerable significance is the fact that some of the polyps, in cases of multiple polyposis, almost invariably become malignant, and these are indistinguishable from the ordinary solitary adenoma.

In a series of 827 patients with carcinoma of the colon and rectum, Swinton and Warren¹ demonstrated histologically that 14 per cent had arisen in benign mucosal polyps. Buie and Brust² report four patients in whom polyps were found, but were not removed, and in whom carcinomas developed later in the same section of the rectum.

Further support of the belief that the adenoma is a premalignant tumor is found in a study of the age incidence. Martin,³ Buie and others have shown that the average age of patients with polyps is about ten years younger than the group with carcinoma. Also, their comparative figures of the location of the lesions show a very great similarity.

If it is true that malignancy not infrequently arises in benign polyps, greater efforts should be made to diagnose these tumors early in order that proper treatment may be instituted.

SYMPTOMS

In reviewing the histories of patients with such tumors, the impression is gained that the symptoms do not greatly differ from those of any tumor of the rectum. In fact, there are no symptoms that are diagnostic of any one pathological condition.

When very small, and even when, at times, the polyp reaches considerable size, symptoms referable to the ano-rectal region may be absent, and the presence of the tumor noted on routine proctoscopic examination. This is especially true of the villous papilloma, which may almost fill the rectum yet produce few symptoms.

Bleeding of some type is the most frequent symptom, and may occur before, with or after the stool, and may be mixed with mucus. It may be fresh or altered and may occur in any amount. A change in bowel habits is especially significant of a tumor. In some, tenesmus and the passage of frequent small stools is present, and in others constipation from the obstruction of a large polypoid mass. Pain of a dull, aching character, pain in the back, a feeling of fullness in the rectum or the discomfort of a protruding tumor are not infrequent.

DIAGNOSIS

The diagnosis is made on physical examination and laboratory studies. Examination should consist of a careful, thorough digital examination,

followed by visualization of the well-prepared bowel. This is usually possible for a distance of ten inches and it is rare that the tumor cannot be either palpated or visualized, and a fairly accurate idea gained as to its type and the possibilities of malignancy. Ulceration, induration or fixation

not carried out routinely when symptoms suggestive of a tumor are present, and yet this continues to be our greatest diagnostic problem. The other error is incomplete examination, and, at times, this has a more rational basis. It is especially easy to neglect proper examination when a



Fig. 1.—Adenoma malignum, showing considerable irregularity and variation in glandular structure with suggestion of anaplasia.

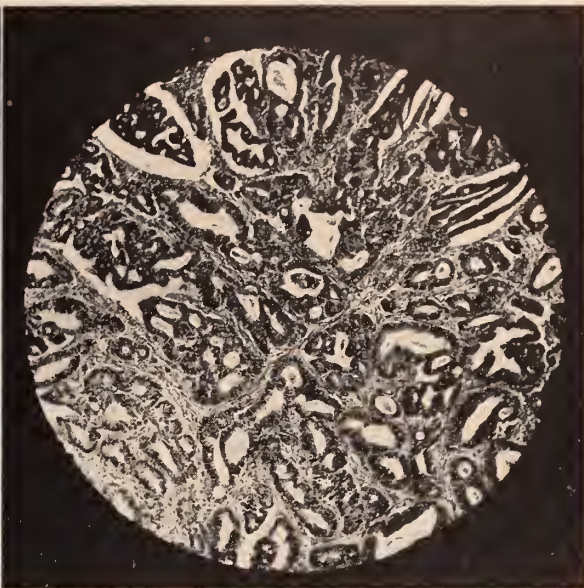


Fig. 2.—Adenocarcinoma grade two, arising in an adenoma.

should be looked upon as very suggestive of malignancy. Sessile types of tumors have not appeared to be more frequently malignant than the pedunculated variety. As Buie and Brusk state: "The malignant change, when it occurs, is toward the periphery of the polyp, and such a carcinogenetic impulse would not appear to be dependent upon the presence or absence of a stalk."

If it seems advisable, material for biopsy may be removed without danger. The possibility of disseminating a malignancy seems to be very remote, and the only danger is hemorrhage, which can always be controlled. However, biopsy is not entirely reliable, because only a small piece can be removed and may not be obtained from the proper location to show an early malignancy. The study of the entire tumor is of much greater importance. This may easily be done with the pedunculated type; but in the sessile variety, the biopsy must be relied upon as diagnostic, as the entire tumor may be destroyed by the treatment.

X-ray study, especially by the air-contrast technic, is advisable if symptoms suggesting a tumor are present with negative instrumental examination, or to determine the presence of other polyps. It should be emphasized again, however, that the lower few inches of the large bowel are difficult to satisfactorily examine radiologically, and also that instrumental examination should precede the x-ray study.

Errors are chiefly those of omission. It is rather difficult to understand why proper examination is

painful lesion of the anal canal is found to be present, which might easily account for all the symptoms, and one must be constantly on guard against such an error.

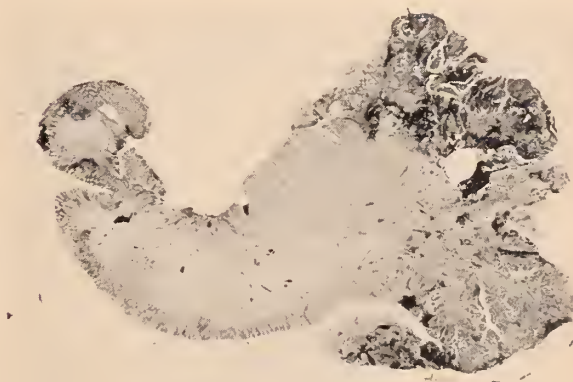


Fig. 3.—Low power of malignant polyp. No evidence of invasion of bowel wall.

TREATMENT

The type of treatment indicated rests on the clinical diagnosis to a great extent. If the lesion appears to be benign, it is my opinion that one should rely on local excision or destruction. The sessile tumors should be destroyed by fulguration, or the cautery, and the pedunculated tumors re-

moved by ligation of the pedicle or preferably with the fulgurating snare. With the large, low-lying villous papilloma it may be simpler to excise the entire tumor with the cautery, thereby removing it with its base, rather than attempt destruction by fulguration.

Two dangers are ever present, perforation and bleeding. Below the peritoneal reflection, destruction of the entire thickness of the bowel wall is ordinarily of little consequence, but above the reflection it is possible to perforate the wall at the time of the operation or subsequently by the sloughing of the tissue. Should this accident occur, the abdomen must be opened immediately and the defect repaired. With our present chemotherapy this can very probably be done without the tremendous mortality attached to such operations in the past.

Hemorrhage is not ordinarily difficult to control, but may be of alarming amounts, and in attempting to stop it the bowel may be perforated. Because of these possibilities, which are less apt to occur if everything is at hand for the proper care of the patient, hospitalization is very desirable.

Cases may present themselves that, because of the size, location or evidence of possible malignancy, require excision by laparotomy and opening of the bowel. This method is not without a definite danger of increased mortality and morbidity; but with proper preoperative preparation, may be accomplished without undue risk.

is indicated, must be decided in each individual case.

The grade of malignancy in such tumors is apparently invariably low, but should be determined pathologically in each case, for the clinical picture of a polypoid type of frank carcinoma may be difficult to distinguish from the less malignant polyp of grade one or two. Of probably greater importance is clinical or pathological evidence of involvement of the bowel wall. Clinically, this is evidenced by thickening and induration of the wall and a tendency to fixation. Ulceration is suggestive of malignancy, but may be due to trauma to the growth, and is of little pathological or diagnostic significance.

Histologically, it may be very easy to determine invasion of the wall of the bowel if any of the wall is removed with the specimen, or by inference one may assume invasion, if there is involvement of the stalk and base of the polyp.

In some, the question of diagnosis may arise, for the evidence of malignancy may be very slight, with only a suggestion of anaplasia but with considerable irregularity and variation in the glandular formations—that is, the so-called adenoma malignum. (Fig. 1.) In others no difficulty in making the histological diagnosis is found, for the tumor is very obviously malignant. Figure 2 is a photomicrograph of a grade-two malignant polyp which was removed five years ago. There was no evidence of invasion either clinically or microscopically, and there has been no evidence



Fig. 4.—Higher power photomicrograph of border of malignant area.



Fig. 5.—Photomicrograph of a villous papilloma.

When dealing with an adenoma that shows malignant degeneration, either on biopsy or after removal of the tumor, there are certain factors that must be considered and determined in order to institute proper treatment. Whether the surgeon is justified in depending on local removal or destruction, or whether a resection of the rectum

of recurrence.

As stated previously, biopsy at times leads to a false diagnosis, and this can be very well demonstrated in a study of a malignant polyp removed three years ago from an elderly male. (Figs. 3 and 4.) The line of demarcation between the benign and malignant portion of the polyp is very

sharp and the adenocarcinoma might easily be missed without a study of the entire tumor.

Recurrence is suggestive, but not necessarily conclusive evidence of involvement of the wall. Four years ago a sessile polyp was removed from a woman of 66 and diagnosed as a grade-one adenocarcinoma, the changes being limited to the mucosa without evidence of invasion below the muscularis mucosa. Two years prior to that a malignant polyp had been removed from the same location by the referring physician, and the area treated with radium. Of course, this second growth may have been a new tumor, but the location was apparently the same and no scars of previous surgery could be found.

Multiple tumors are not infrequent and these may not show the same characteristics. A very large villous tumor (Fig. 5) was removed from the lower rectum four years ago, and three years later, during a routine check-up, a polyp was found in the sigmoid approximately 1.5 centimeters in diameter. This was removed and diagnosed as an adenoma malignum. Three other very small tumors in this patient have been removed, and it is very evident that there is a tendency to neoplastic formation in this individual.

There is more or less agreement as to the proper treatment of these malignant polyps. Stone⁴ believes that radical operation should be performed, if and when invasion of the rectal wall is determined. Yeomans⁵ has suggested the use of radon seeds in the wall after destruction, or removal of the growth by fulguration or the high frequency snare. David⁶ expresses perhaps a more radical view, saying that the slightest evidence of ulceration or induration of these tumors is highly significant of malignancy, and radical removal of the bowel is indicated.

As yet, I have not regretted local removal or destruction of these malignant polyps, and do not believe that removal of the entire rectum is justifiable without very certain and conclusive evidence of bowel wall involvement. One should make every effort to examine such patients at regular intervals, for at least three and preferably for five years after removal of the tumor.

Occasionally a very frank, high grade malignancy resembles very closely a sessile benign polyp, and the diagnosis is made only on careful visualization and, if possible, palpation, and on biopsy which should be repeated if there remains any question as to the diagnosis. In these the most conservative treatment would appear to be radical resection, and any variation from this must be justified by unusual circumstances. It would seem probable that such tumors originate as carcinomas, and that the wall is involved early with the possibility of early involvement of the lymph nodes. Occasions may arise where local treatment seems indicated, but with one possible exception my experience with fulguration of such lesions has been unsatisfactory.

This was a small polypoid lesion, not over 1.5 centimeters in diameter on the anterior wall four inches within the rectum, occurring in an obese male of 58, who had an apparently arrested

neurosyphilis and cardiorenal disease. Biopsy showed a grade-three adenocarcinoma. It was destroyed by fulguration four years ago, and so far there has been no evidence of recurrence.

SUMMARY

In summary, it is believed that all polyps of the rectum should be treated as potentially malignant lesions and immediately removed. The most frequent error in diagnosis is that of omitting proper examination of the rectum and sigmoid, when symptoms referable to that area are present.

Local destruction or removal is adequate for the benign adenoma, the villous papilloma and the malignant polyp, unless clinical and histological evidence is found indicating involvement of the bowel wall. For frank malignancies, radical surgical removal of the bowel is always indicated.

1136 West Sixth Street

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MEDICAL EPONYM

Moebius's Sign

The first mention of this sign was made by Moebius in a review of Pierre Marie's *Contribution à l'étude et au diagnostic des formes frustes de la maladie de Basedow* (Paris, 1883). The review appeared in Schmidt's *Jahrbücher der inneren und ausländischen gesammten Medicin* (200:98-100, 1883). A portion of the translation of the former follows:

"Von Graefe has said that lessening or abolition of the synergic movement of the upper lids in raising and lowering the eyes is pathognostic. The reviewer has failed to find Graefe's symptom in a series of cases including some with and some without exophthalmos. He not only disbelieves in its pathognostic character, but considers it rather rare. On the other hand, the reviewer has recently observed a disturbance of convergence in two patients with Basedow's disease, both of whom had a moderate bilateral exophthalmos of equal degree. If the patient was asked to fix his vision on the examiner's finger, both eyes looked to the right or to the left. That is, the patient fixed with one eye, and the external muscles of the other eye contracted consensually. On monocular examination, both internal recti functioned normally. In a third patient with exophthalmos, the symptom was absent. Whether the phenomenon is directly dependent on the exophthalmos is uncertain."

The subject was again discussed, and observations in eight additional cases were reported, in an article, *Über Insufficienz der Convergenz bei Morbus Basedowii* [Convergence Insufficiency in Basedow's Disease], which was published in the *Zentralblatt für Nervenheilkunde, Psychiatrie und gerichtliche Psychopathologie* (9:356-358, 1886).—R. W. B., in *New England Journal of Medicine*.

The business of life is to go forward.

—Samuel Johnson, *The Idler*. No. 72.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

Resignation of Louis A. Packard, M.D., Bakersfield (Councilor of Third Councilor District) and Election of Harry E. Henderson, M.D., Santa Barbara, to Fill Councilor Vacancy

At the meeting of the C.M.A. Council held on September 13th, Doctor Louis A. Packard, Councilor for the 3rd District (Counties of Kern, Santa Barbara, Ventura, San Luis Obispo and Inyo-Mono) submitted his resignation, stating he was about to take up practice in McAlester, Oklahoma.

The Council requested the component county societies to submit nominations. By mail vote, the Council has elected Harry E. Henderson, M.D., to act as Councilor of the Third District.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals: For Colleagues in Military Service

In this issue appears editorial comment on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in cooperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

This notice will appear in this department every month.

If you have not read the editorial outline of the plan in the September issue, you are urged to do so.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals to: C. M. A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California.

† Harold A. Fletcher, M.D., 490 Post Street, San Francisco, is the State chairman for Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M.D., 1930 Wilshire Boulevard, Los Angeles.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1321, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (DRexel 5241).

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Teleph one EXbrook 3386, Local 46.

For the southern section of the State, the Office of Naval Officer Procurement is in charge of Lt. Comdr. John P. Ewing, MC. The office is located at the Naval Armory, 850 Lilac Terrace, Los Angeles.

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

† For complete roster of officers, see advertising pages 2, 4, and 6.

Status of Medical Personnel: Procurement and Assignment Service

(COPY)

OFFICE OF WAR INFORMATION, WAR MANPOWER COMMISSION†

To the Editor.—“The Directing Board of the Procurement and Assignment Service is pleased to announce that 95 per cent of the 1942 procurement objective of medical officers for the armed forces has already been met. Toward this total a number of States have supplied more than their share of physicians and only a few States are lagging behind in their quotas. It is from these States that the additional physicians needed during the current year should come.

“The recruitment of such a large number of physicians in a few months is a remarkable achievement and another demonstration of the traditional patriotism and unselfishness of the medical profession. In this achievement, and particularly in those of its members who are “in service,” the profession can justifiably take pride.

“The end, of course, is not yet. Increases in the armed forces will necessitate more medical officers and additional demands will be made upon the profession for medical services in critical war production areas. The Directing Board is convinced, however, that the physicians of this country will respond to future calls for service, whatever they may be, in the same splendid manner with which they have already volunteered for service with the armed forces.”

(Signed) FRANK H. LAHEY, M. D.
HAROLD S. DIEHL, M. D.
HARVEY B. STONE, M. D.
JAMES E. PAULLIN, M. D.
C. WILLARD CAMALIER, D. D. S.,
of the Directing Board.

Civilian Defense—Emergency Base Hospitals*

(COPY)

The Medical Division of the U. S. Office of Civilian Defense, through its Regional Medical Officers and State Chiefs of Emergency Medical Service, has now made emergency provision for the establishment of a chain of Emergency Base Hospitals in the interior of all the coastal States. They will be activated only in the event of an enemy attack upon our coast which necessitates the evacuation of coastal hospitals. Each base hospital will be related to the casualty receiving hospital which has been evacuated and it is expected that the staff will be recruited largely from the parent institution.

In order to meet a sudden and unexpected crisis without delay, arrangements have been completed with State authorities for the prompt taking over of appropriate institutions in the interior of the State for this purpose and with local military establishments for the transportation of casualties and other hospitalized persons along appropriate lines of evacuation.

More than 150 hospitals in the coastal cities are in the process of organizing small affiliated units of physicians and surgeons, which will be prepared to staff the Emergency Base Hospitals if they should be needed. These units are composed of the older members of the staff and those with physical disabilities which render them ineligible for military service, and of women physicians. In order that a balanced professional team

may be immediately available the doctors comprising units are being commissioned in the inactive Reserve of the U. S. Public Health Service so that, if called to duty, they may receive the rank, pay and allowances equivalent to that of an officer in the armed forces.

Dr. George Baehr, Chief Medical Officer of the U. S. Office of Civilian Defense, states that the members of these affiliated hospital units will continue to remain on an inactive status for the duration of the war, unless a serious enemy attack occurs in their Region which necessitates the transfer of casualties to protected sites in the interior. Their commissions may be terminated upon their request six months after the end of the war, or sooner if approved by the Surgeon General. Such approval will be given in the event such officer desires active duty in the Army or Navy.

Alien Physicians

In Relation to Service with the Armed Forces and in Civilian Practice

The following statement by the directing board of the Procurement and Assignment Service has just been sent to State chairmen for physicians:

The Army and the Navy are not in a position to accept enemy alien physicians as commissioned officers because of the citizenship law.

Also many of these physicians do not meet other requirements such as license to practice, internship or other professional qualifications. It therefore seems inadvisable to recommend that these aliens go into the Army as privates with the expectation of receiving citizenship at the end of three months for many may not receive it for some reason, and they may not be acceptable to the Medical Corps even though they are given citizenship.

Since there are many places in which these men can be of service in civilian life, it is recommended that efforts be made to place those who are not acceptable for service with the Army or the Navy as temporary employees in hospital positions, in critical areas where more physicians are needed, in special positions in medical schools, and in public health agencies and so on. In such positions they may be rated as essential and may thus be used in their professional capacity.

Until definite rulings are made concerning the admission of this group into the military services, these general policies should be followed.—*Jour. A.M.A.*, Oct. 31, 1942.

New Demand to Mobilize All Manpower

“Guess Work” System Attacked at Senate Hearing; Doctors Volunteering Is Deplored

Washington, Nov. 2—(AP)—A new demand for a compulsory manpower mobilization program came today from Senator Hill, Democrat of Alabama, after a priest and physician sketched for a Senate Labor Committee a picture of a nation striving for utilization of its human resources under a “guess work” system lacking coordination and authority.

The appeal of patriotism and the pressure of war time public opinion—particularly in smaller cities—were blamed by Dr. Frank Leahy, chairman of the Government's Central Board of Procurement and Assignment for the Medical Profession for a shortage of doctors in some sections of the country.

Doctors Volunteer

In many areas too many doctors were volunteering, he said. In order to keep them in their home community, “there should be some way whereby responsibility

† Communication received on October 29, 1942.—Ed.

* Bulletin received from the Office of Civilian Defense, Washington, D. C., on October 15, 1942, and addressed to Medical, Hospital, Nursing, Public Health and Related Journals.

for the decision would be taken off the individual physician."

"You simply can't get your maximum results from a voluntary system," Hill, member of the committee and Democratic whip of the Senate, commented. "In a total war, you've got to meet your total needs and the only way to do this is by an overall selective service."—San Francisco *Examiner*, November 3.

Re: 'Teen Age Inductees—Emotional Stability

To the Editor.—Sir: So much has been said and so much implied about the desirability of drafting 18 and 19 year old men for military service from the viewpoint of emotional stability that it seems that in the public interests that a simple, direct statement should be made on this question.

Speaking as individuals, we wish to assure the public and parents of this age group that there are no grounds for apprehension as to the effect of military service on these younger men as distinguished from the older men. Such statistics as are available indicate that the incidence of mental breakdowns is no greater in the 18 and 19 year age group than in the older group. If anything, it is somewhat less. It would seem to us that the proposal now before the American Congress does not unduly compromise the future mental integrity of this particular age group or of the Nation. With the Government realizing and properly assuming this increased responsibility, we endorse favorable action upon the proposal to include men of 18 and 19 years under the selective service act.

ADOLPH MEYER, M. D.,
Professor Emeritus of Psychiatry, Johns Hopkins University, Baltimore, Md.

C. MACFIE CAMPBELL, M. D.,
Professor of Psychiatry, Harvard University, Cambridge, Mass.

FOSTER KENNEDY, M. D.,
Professor of Neurology, Cornell University, Ithaca, N. Y.

C. CHARLES BURLINGAME, M. D.,
Psychiatrist in chief, Neuro-Psychiatric Institute, Hartford, Conn.

EDWIN G. ZABRISKIE, M. D.,
Professor of Clinical Neurology, Columbia University, New York, N. Y.

WINFRED OVERHOLSTER, M. D.,
Supt. St. Elizabeth's Hospital, Washington, D. C.

S. BERNARD WORTIS, M. D.,
Professor of Psychiatry, New York University, New York, N. Y.

TRACY PUTNAM, M. D.,
Professor of Neurology, Columbia University, New York, N. Y.

OSCAR DIETHELM, M. D.,
Professor of Psychiatry, Cornell University, Ithaca, N. Y.

Re: Emergency Base Hospitals in Seaboard States

At the recent meeting of the Trustees of the American Medical Association in regard to Inactive Reserve Commissions in the United States Public Health to Organize Evacuation Hospital Units, following action was taken:

"The Vice-President, Dr. W. J. Carrington, made the following report:

"The Federal Security Administrator, under authority vested in him by the President, charged the U. S. Public Health Service with the responsibility for providing civil-

ians with medical care and hospitalization necessitated by enemy action. Accordingly, certain hospitals in seaboard states have been invited by Surgeon General Parran to organize affiliated units in the U. S. Public Health Service to facilitate prompt evacuation of important coastal cities if the need arises. He has designated certain of these as emergency base hospitals and would supplement their staffs by units made up of physicians in the affected areas.

"A unit is composed of fifteen doctors, over 45 years of age, and those with physical disabilities which disqualify them for active military service but which do not interfere with their professional activities. The members of the unit are placed on the U. S. Public Health Service reserve list but become activated by order of Surgeon General Parran in a grave emergency on the request of the Office of Civilian Defense on the advice of the regional medical officer and the state chief of Emergency Medical Service. On activation the fifteen men will receive pay, allowance and rank equivalent to captains, majors and/or lieutenant colonels.

"The hospitals in the affected areas would like to have the approval of the Board of Trustees of the American Medical Association before accepting the invitation to organize affiliated units."

"The Board felt that the organization of hospital units in the U. S. Public Health Service to be called into action in the time of enemy action in emergency only and for no other purpose is a reasonable measure."

PRO PATRIA†

C.M.A. MEMBERS IN MILITARY SERVICE

San Benito County Medical Society

Members of the San Benito County Medical Society on Active Duty with the Army or Navy.

(Report, as of October 20, 1942. Total Number, 3.)

Name	Rank (if known)	Service (if known)
Brown, Ronald E.	Royal Canadian Air Force	
Geen, Robert S.		Army
Noland, Roy F.		Army

Santa Clara County Medical Society

Members of the Santa Clara County Medical Society on Active Duty with the Army or Navy.

(Report, as of October 22, 1942. Total Number, 59.)

Name	Rank (if known)	Service (if known)
Anderson, Frank B.		Navy
Arminini, George B.		Army
Arnold, H. J.		Army
Badami, Anthony G.		Army
Barrett, Pierce C.		Army Air Corps
Bilker, Danial.		Army Air Corps
Billingsley, Gordon D.		Army
Blanchard, Leland B.		Army Air Corps
Campisi, Dominic A.		Army
Carlson, Carl O.		Army
Cassell, Irving.		Navy
Chaiken, Louis P.		British
Chesbro, Wayne P.		Navy
Cilly, Herbert.		Air Corps
Cook, Enos P.		Navy
Cragin, Robert B.		Army
Cressman, Ralph D.		Army
Davis, Gerald.		Army Air Corps
Fox, Leon P.		Navy
Francis, Kenneth V.		Army
Geisler, Wm.		Army
Gerstel, Mark L., Jr.		Navy

† County Society Secretaries are requested to submit names of members who are in military service.

Haley, Philip S.....	Navy	Ching, C. M. S.—1st Lieut.....	Army
Henderson, Emmett E.....	Army Air Corps	Churchill, A. G.....	—
Hockenbeamer, Ernest B.....	Navy	Colby, E. G.....	National Guard
Ishikawa, Tokio.....	Army	Cooper, A. J.....	Army
Jenkins, Herbert T.....	Army	Corbin, Damon E.....	—
Jorgensen, Melford B.....	Army	Denny, Lorin W.—1st Lieut.....	Army
Josephson, Joseph B.....	Navy	Egan, A. R.....	Army
King, Robert.....	Air Corps	Eneboe, J. B.....	—
Lane, Henry J.....	Navy	Fehlmann, F. H.—Captain.....	Army
Lawery, Edwin V.....	Navy	Fetter, E. M.....	—
Lee, Russell V.....	Army Air Corps	Findlay, F. M.—Major.....	Army
Leonard, C. D.....	Air Corps	Hanna, C. M.....	Army
Liston, Edward.....	Army Air Corps	Harbaugh, O. S.....	Army
Lyons, Thomas P.....	Army Air Corps	Hartsough, C. W.....	—
Lytle, Howard W.....	Navy	Helming, O. C.....	Army
Maher, Edward J.....	Army	Herbert, W. R.—Captain.....	Army
Mason, Marshall.....	Army	Hoffman, R. L.....	—
Mitchell, Sidney P.....	Navy	Holder, H. G.....	Army
Moore, Farrall H.....	Navy	Hollander, F. G.....	—
Norberg, Raymond W.....	Army	Housvicks, O. A.....	Army
Pace, Paul T.....	Army	Jetton, J. A.....	Army
Pettit, Richard D.....	Army	Kelley, E. H.....	Navy
Pickworth, Max E.....	Army Air Corps	Kilgore, George L.....	Army
Premo, Milton.....	Air Corps	King, R. M.....	—
Pritchard, Jacob L.....	Army	Kirby, Edwin G.—Captain.....	Army
Togozen, Alexander.....	British	Kotler, M. J.—Captain.....	Army
Rouff, Elliot A.....	Navy	Laird, George.....	—
Salvadorini, Vasco A.....	Navy	Lane, C. W.....	—
Smith, H. Gordon.....	Army Air Corps	LeDuc, I. E.....	—
Threlfall, Donald.....	Army Air Corps	Lester, David.....	—
Tucker, H.....	Army	Levy, E. I.....	—
Waters, George.....	Army	Lewis, Wilton M.....	—
Williams, Alvin B.....	Navy	Lindsay, C. V.....	Army
Wilson, John.....	Navy	Lipe, J. T.—1st Lieut.....	Army
Wood, Denniston, Jr.....	Navy	Lounsberry, C. R.....	—
Wood, George.....	Army	Lucie, L. H.....	—
Wright, R. Wesley.....	Army Air Corps	Macpherson, F. L.....	—

Santa Cruz County Medical Society

Members of the Santa Cruz County Medical Society
on Active Duty with the Army or Navy.

(Report, as of October 21, 1942. Total Number, 10.)

Name	Rank (if known)	Service (if known)
Allegrini, A. E.....	Navy	
Gilman, P. K., Jr.....	Navy	
Harrington, J. T.....	Navy	
Havenhill, A. D.....	Army	
Jacobson, J. C.....	Army	
Ludden, J. A., Jr.....	Navy	
Pederson, A. J.....	Navy	
Smith, D. D.....	Navy	
Tipton, S. P.....	Army	
Wood, A. E.....	Army	

San Diego County Medical Society

Members of the San Diego County Medical Society
on Active Duty with the Army or Navy.

(Report as of October 6, 1942. Total Number, 80.)

Name	Rank (if known)	Service (if known)
Alberty, W. M.....	—	—
Banks, G. F.....	Army	
Baxter, C. P.....	Army	
Bernardini, C. V.....	—	—
Callaway, J. A.....	Army	
Cantoni, A. J.....	—	—
Chapman, H. J.....	—	—

Ching, C. M. S.—1st Lieut.....	Army
Churchill, A. G.....	—
Colby, E. G.....	National Guard
Cooper, A. J.....	Army
Corbin, Damon E.....	—
Denny, Lorin W.—1st Lieut.....	Army
Egan, A. R.....	Army
Eneboe, J. B.....	—
Fehlmann, F. H.—Captain.....	Army
Fetter, E. M.....	—
Findlay, F. M.—Major.....	Army
Hanna, C. M.....	Army
Harbaugh, O. S.....	Army
Hartsough, C. W.....	—
Helming, O. C.....	Army
Herbert, W. R.—Captain.....	Army
Hoffman, R. L.....	—
Holder, H. G.....	Army
Hollander, F. G.....	—
Housvicks, O. A.....	Army
Jetton, J. A.....	Army
Kelley, E. H.....	Navy
Kilgore, George L.....	Army
King, R. M.....	—
Kirby, Edwin G.—Captain.....	Army
Kotler, M. J.—Captain.....	Army
Laird, George.....	—
Lane, C. W.....	—
LeDuc, I. E.....	—
Lester, David.....	—
Levy, E. I.....	—
Lewis, Wilton M.....	—
Lindsay, C. V.....	Army
Lipe, J. T.—1st Lieut.....	Army
Lounsberry, C. R.....	—
Lucie, L. H.....	—
Macpherson, F. L.....	—
Macpherson, J. D.....	—
Maguire, J. M.....	—
Maggio, G. E.....	—
Marsden, C. S., Jr.—1st Lieut.....	Army
Matson, J. R.....	Army
McIver, Robert—Captain.....	Army
Mehlin, G. B.....	—
Minna, J. B.....	Army
Moffitt, L. W.....	Army
Morris, G. W.....	Army
Mullenix, R. B.....	—
Newton, Hiram D.....	—
O'Farrell, Norman.....	—
O'Hara, F. P.....	—
Olds, John W.....	—
Palevsky, S. N.....	Army
Paull, Ross.....	Army
Plagens, George M.....	Army
Present, A. J.....	Army
Redell, John C.....	—
Reeves, I. E.....	—
Richey, Tim V.....	—
Robinson, F. H.....	Army
Ryan, W. J.....	—
Seiler, W. E.....	Army
Svoboda, F. C.....	Army
Tancredi, C.....	—
Thomas, J. W.....	Navy
Wedgewood, P. E.....	—
Werden, D. H.....	—
Whitelock, T. S.—Captain.....	Army
Wilson, I. H.....	—
Young, E. L.....	Army
Yuskis, Anton S.....	—
Zukovich, C. E.....	—

General Hospital No. 30*

UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL

Name	Rank	Assignment
Hein, Gordon E.	Lieut. Col.	Medicine
Rhodes, George K.	Lieut. Col.	Surgery
Birnbaum, Walter	Major	Surgery
Clark, Albert G.	Major	Surgery
Lindner, Harold H.	Major	Surgery
Mote, Clayton	Major	Medicine
Palmer, Allan	Major	Laboratory
Soto-Hall, Ralph	Major	Orthopedic Surgery
Stevens, Howard B.	Major	Thoracic Surgery
Rosson, Charles T., Jr.	Major	Surgery
Clausen, Edwin G.	Captain	Surgery
Eastman, Kenneth M.	Capt. MAC.	Det. Co. & Asst. Adj.
Elliot, James S.	Captain	G. U. Surgery
Lennon, Thomas J.	Captain	Medicine
Pencharz, Richard	Captain MAC.	Supply and Mess
Schindler, Meyer	Captain	ENT
Rice, Arthur H.	Captain	ENT
Rochex, Francis J.	Captain	Medicine
Ryder, William B., Jr.	Captain	Dental Clinic
Brown, John W.	1st Lieut.	Medicine
Cherney, Leonid S.	1st Lieut.	Surgery
Crede, Robert H.	1st Lieut.	Medicine
Erpf, Stanley F.	1st Lieut.	Dental Clinic
Castiglione, John	1st Lieut.	Medicine
Covel, Martin B.	1st Lieut.	Medicine
DeLear, Edward C.	1st Lieut.	Registrar
Forcade, William P.	1st Lieut.	Medicine
Holko, John E.	1st Lieut.	Medicine
Kelley, Douglas M.	1st Lieut.	Neuropsychiatry
Leonard, Maurice E.	1st Lieut.	Medicine
Pfister, Joseph J., Jr.	1st Lieut.	Dental Clinic
Segal, A. Lawrence	1st Lieut.	Surgery
Sweet, Norman J.	1st Lieut.	Laboratory
Thompson, James H.	1st Lieut.	Medicine

Military Clippings—Some news items of a military nature from the daily press follow:

"Freezing" Physicians and Surgeons

Sacramento, Oct. 27.—(AP.).—Senator Claud Pepper, of Florida, chairman of a labor sub-committee of the U. S. Senate committee on education and labor, today disclosed his group has virtually agreed to recommend a three-point program to solve the nation's manpower problem.

Already approved by three members of the five-man group, he said is a report favoring:

(1) Authorization by Congress of the taking of a quick sample census to bring the 1940 census up to date to provide information upon which a manpower allocation policy can be based.

(2) Adoption of a policy of freezing physicians and surgeons "where they are now" to avoid denuding the civilian population of necessary professional services.

(3) Creation of a national deferment board to govern the deferment from military service of those whose services are vitally needed in civilian industry.—San Francisco *Call-Bulletin*, October 27.

* * *

No Commissions: Women Medics Raise Protest**Doctors Demand Officers' Posts with Combat Forces**

New York, Oct. 13 (AP.).—The men may have thought they were being big-hearted when they agreed to give women doctors commissions in the WAVES and WAACS. But the women doctors are far from satisfied.

"We want complete equality and this isn't it," said Dr. Emily Dunning Barringer in an interview today. "We want commissions in the Army Medical Reserve Corps, not in female auxiliaries."

Doctor Barringer, of the American Medical Women's Association, for years has led the movement for equal rights for women doctors. . . .—Oakland *Tribune*, October 13.

* Medical Schools in California were requested to submit rosters of General Hospital units. General Hospital Unit No. 30 was called to active duty on May 15, 1942, and is now serving overseas.—Ed.

Draft Policy

Washington, Oct. 31 (UP.).—The Army's need for men has reached the point where continued deferment of physically fit men will be based increasingly on essential usefulness in civilian life, selective service officials said today (October 31, 1942).

Married men who have children remain at the bottom of the draft lists, regardless of the nature of their jobs, but those with wives only are being rapidly reclassified on an occupational basis, and many of them soon will be called.

This reclassification is based on a list of 34 essential industries issued in July. Selective Service headquarters has urged local boards to speed reclassification because pools of single men are virtually exhausted.

Married men who have any job in one of the 34 essential industries are being reclassified at 3-B. This signifies deferment for both dependency and occupational reasons.

Call for 3-A's

Married men who do not work in these industries remain in class 3-A, deferred for dependency only. And calls for induction of these men are expected to begin in November.

The draft of 3-A men will be interrupted to take in the expected class of 18 and 19 year olds, but it will be resumed in the late winter or early spring.

To build up the Army to the 7,500,000 goal set for 1943 will require all the 3-A men who are physically suited for the Army and who do not have children. It also is expected to require a great many of the 3-B men. Drafting of this class probably will start by the middle of next year, although variable factors might advance or retard the time.

A man reclassified now as 3-B is not assured of permanent deferment. The deferment is good only until the childless 3-A men are exhausted.

Deferred as Key Men

When this occurs, the 3-B men will be reexamined. Continued deferment then will depend not only on being employed in one of the 34 essential industries but on being an irreplaceable key man in one of those industries.

Essential Industries

The 34 industries termed essential and in which automatic temporary deferments are being made are:

Production of aircraft and parts, production of ships, production of ordnance, production of ammunition, agriculture, food processing, forestry, logging and lumbering, construction, coal mining, metal mining, nonmetallic mining and quarrying, smelting and refining metals, production of forgings, finishing of metal products, production of industrial and agricultural equipment, production of machinery, production of chemicals, production of rubber products, production of leather products, production of textiles, production of apparel, production of stone, clay and glass products, production of petroleum and similar products, production of finished lumber products, production of transportation equipment, transportation services, production of materials for packing and shipping, production of communication equipment, communication services (including newspaper and radio stations), heating power and illuminating services, repair and hand trade services, health and welfare services, educational services, governmental services.

Order of Call

The complete order in which registrants are subject to call is as follows:

1. Single men with no dependents; class 1-A. This class is virtually exhausted.

2. Single men in nonessential industries, but who have dependents; class A-3. Largely exhausted.

3. Single men, with dependents, in essential industries; class 3-B. (Each man's case subject to review; registrants found to be key men in essential activities continue temporarily deferred while the call moves on to the next class.)

4. Married men in nonessential industries who maintain a bona fide family relationship with a wife only, class 3-A.

5. Married men in essential industries who maintain a bona fide family relationship with a wife, class 3-B. (Subject to review individually when liable to call, and key men sorted out for temporary deferment.)

6. Married men in nonessential industries who maintain a bona fide family relationship with a wife and children or children only. Class 3-A, but not to be called in unless above 3-B are exhausted.

7. Married men in essential industries who maintain a bona fide family relationship with wife and children or children only; class 3-B.—San Francisco *Chronicle*, November 1.

Physician Supply for Armed Services and Civilian Communities

Telephone doctors early in the morning . . . avoid requesting home visits . . . avoid calling doctors during office hours . . . limit appointments to necessary ones . . . and be prompt!

When the San Francisco County Medical Society handed out this advice to the civilian population last summer, it foresaw an alarming shortage of civilian doctors. There were 176,000 physicians in the whole country, and the Army and Navy had plans to take 60,000 of them by the end of 1942. With only about 10,000 doctors in California the armed forces had taken or would take 3,000 of them. The situation was the same throughout the United States.

The problem, however, was not the number of doctors available. Sweden had a good health record with only one physician per thousand population. The problem at hand was the distribution of doctors.

Last week in a Senate Labor Sub-Committee hearing, Chairman Claude Pepper (D., Fla.), charged that haphazard recruiting of doctors had led to tremendous, unnecessary over-militarization of the doctor supply at the expense of the civilian population. His committee suggested that any further recruiting should operate as an orderly withdrawal which would not cripple the medical services of any community.

The committee's recommendation was the springboard for a hot argument. Surgeon General Frank Parran refused to recommend compulsory assignment of doctors to private practice, but did not question the committee's fact-finding ability.

Dr. Morris Fishbein, editor of *American Medical Journal*, was not so polite. Through the *Journal* of the A.M.A., he flatly accused Pepper's committee of lacking information as to what had already been accomplished to meet the needs of the situation. When the committee asked for an inventory of available physicians, Fishbein countered that these inventories had already been made by the A.M.A. in 1940, and by the Procurement and Assignment Service in 1941.

Author-Doctor Paul DeKruif (*Microbe Hunters, Health and Wealth*), erstwhile member of the A.M.A., went to bat for Pepper's committee, apparently horrified at the idea of the A.M.A. controlling the national health program or the mobilization of doctors. He cited numerous instances in which, he claimed, A.M.A. officials had "put the finger" on leading doctors in an attempt to "force" them into the Army, and thereby lessen competition.

Fishbein sarcastically retorted: "It was quite evident that Dr. DeKruif, as is usual in his writings in the field of medicine, made no effort to obtain the actual facts as to the numbers of doctors, their distribution, the methods by which they can be secured by the Army or the steps taken to insure medical service for the civilian population."—*San Francisco Chronicle*, November 8.

* * *

Medical School Changes Urged

Louisville, Ky., Nov. 6.—Medical school courses in military medicine for the young men who will be tomorrow's Army and Navy surgeons should include such subjects as first aid, sanitation and hygiene, tropical and aviation medicine, Dr. Edwin P. Lehman, of the University of Virginia, declared before a meeting here of the Association of American Medical Colleges.

This advice to medical school deans and faculty members was part of a report on changes in undergraduate teaching as a result of the war. . . .

Prevention and control of venereal disease, surgery of wounds, treatment of burns and frostbite, blast injuries, kidney failure from crash injuries, immersion foot, poison gases, insect bites, developments in sulfa drug treatment, and common psychiatric conditions are other subjects the committee advised teaching to medical students in wartime.—*San Francisco News*, November 6.

* * *

Draft Threat Charged By Doctor Sidney Garfield

Washington, Nov. 6.—(AP.)—The medical director for Henry J. Kaiser's west coast shipyards declared today some members of the organized medical profession were threatening to lay Kaiser Company doctors open to the draft unless they dropped certain group health activities. . . .

The statements were made at a lively session of a Senate labor subcommittee studying manpower problems and led to several tiffs between Kaiser and Doctor Fishbein, editor of the A.M.A. *Journal*.

Dr. Sidney Garfield, Kaiser's medical chief, said the threats were made by physicians of the procurement and assignment service, a branch of the War Manpower Commission charged with procuring doctors for the armed services.

Doctor Garfield testified the chairman of the service in the State of Washington, whom he did not name, was president of the State Medical Society's executive committee, that the service "represents the views of the American Medical Association," and that "the medical profession does not like prepaid medicine."

Charges Threat Made

The company instituted a plan under which workers pay 50 cents a week, which entitles them to medical attention for themselves and their families when necessary. Doctor Garfield testified the State procurement chairman had threatened, in effect, that Kaiser doctors would be drafted if they served the employees' families on the prepayment basis.

Kaiser himself detailed the medical situation in the shipyards and asked Doctor Fishbein, "What would you do in my case?"

"If I were you," Doctor Fishbein answered, "I would ask my medical director not to sit there but to look into all the possibilities and go to those (Federal agencies) who have the information on how to meet the problem."

Doctor Fishbein remarked it was impossible to build new hospitals because of inability to obtain materials, but Kaiser observed, "We are doing it."

"You are a very strong man, Mr. Kaiser," Doctor Fishbein remarked.—*San Francisco Examiner*, November 7.

* * *

Large Gatherings Still Permitted

(Note. Item of Interest to Medical Associations)

Pasadena, Nov. 6.—(AP.)—The Rose Bowl football game, transferred to the east coast last year when California went on an all-out war footing, will return to Pasadena next New Year's Day, an unimpeachable source said today.

The Associated Press learned that the formal application has not yet been sent to the western defense command, but that it will be approved when it is received. The source of the information cannot be disclosed. . . . —*San Francisco Examiner*, November 6.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Postgraduate Week in Los Angeles

The course will be conducted under the auspices of the School of Medicine of the College of Medical Evangelists, during the week, December 7-11, 1942.

Courses Offered.—Applied Anatomy, Anesthesiology, Cardiology, Chest Surgery, Dermatology, Differential Diagnosis, Gastro-Enterology, General Surgery, Military Surgery, Manikin Obstetrics, Minor Orthopedic Surgery, Neurology, Nutrition, Otolaryngology, Proctology, Traumatic Surgery, Urology, Varicose Veins.

Reservations must be made early. Descriptive folder will be sent on request. For information, address: Postgraduate Extension Courses, 312 N. Boyle Ave., Los Angeles, California.

Los Angeles Mid-Winter Study Course on Eye, Ear, Nose and Throat

The Research Study Club of Los Angeles makes the following preliminary announcement of its twelfth annual Mid-Winter Postgraduate Clinical Course in Ophthalmology and Otolaryngology, to be held January 18 to 29:

In certain parts of the country some well-meaning people have thought it best to discontinue scientific meetings on account of the war. The attitude of the Research Study Club is exactly the opposite.

This preliminary announcement gives the general outline of the courses. Those desiring the final program will

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

please write to The Research Study Club, 2509 West Washington Blvd., Los Angeles.

The teaching staff next January comprises a large group of guest speakers.

Harold Irving Lillie, M.D., of Rochester, Minnesota, will give the principal ear, nose and throat lectures. For many years he has been the head of the Department of Otolaryngology of the Mayo Foundation of the University of Minnesota.

Judd Sylvester Beach, M.D., of Portland, Maine, ophthalmic surgeon, Maine Eye and Ear Infirmary, and former chairman of the American Board of Ophthalmology, will discuss his original work in the measurement of astigmatic errors and accommodation.

Georgiana Dvorak Theobald, M.D., of Oak Park, Illinois, assistant clinical professor of ophthalmology, Rush Medical School, will present work on eye pathology.

William Lemuel Benedict, M.D., head of the Ophthalmic Section of the Mayo Clinic will lecture on surgery and orbital tumors.

Otto Barkan, M.D., associate clinical professor of surgery at Stanford University, will bring his new and fundamental concept of the glaucoma problem and its management.

Conrad Berens, M.D., surgeon, pathologist, and director of research of the New York Eye and Ear Infirmary, will discuss eye surgery from the standpoint of some preferred techniques and results of operation.

Frederick Carl Cordes, M.D., professor of ophthalmology of the University of California Medical School, will present newer concepts of fundus pathology and vasodilators.

Chauncey D. Leake, M.D., newly appointed vice-president and dean of the University of Texas Medical School, is one of the best known teachers in his field of pharmacology. His presentations will be directed particularly to the clinical side of the eye, ear, nose and throat, as well as the management of war gases.

Dr. John H. Lawrence, of the University of California at Berkeley, will bring to us the fascinating subject of the cyclotron, and its clinical applications.

Irving B. Lueck, B.S., of Rochester, New York, will take up the analysis of various optical problems relative to anisometropia, presbyopia, aphakia, spectacle reflexions, colored lenses and the standardization of visual acuity measurements.

Captain Leonard W. Hines and Captain A. Carlton Ambler of the Army Air Force, will present "low pressure" changes which occur in aviators, when flying at high altitudes.

Dr. Fred T. Moore of the University of Southern California Medical School staff, will present his laboratory findings and clinical observations.

Dr. Roy Thomas Fisk, of the Research Department of the Huntington Memorial Hospital in Pasadena, will report his "Studies in Pathogenic Staphylococci in Relation to Eye, Ear, Nose and Throat Diseases."

Various other subjects pertaining to the eye, ear, nose and throat will be given by representatives of the medical and technical schools in Southern California, including "Vertigo"; "The Treatment of Deafness"; "Deafness and Audiometry"; "Infections of the Masseter Space"; "Prosthesis of the Middle Ear"; "Vitamin Therapy in Eye, Ear, Nose and Throat"; "The Problem of Sinusitis"; and "X-ray Studies of the Eye, Ear, Nose and Throat."

The fee for the clinical course is \$50.00, one-half being due when the registrant applies to take the course and the remainder upon registration. This is payable to Pierre Viole, M.D., 1930 Wilshire Blvd., Los Angeles.

The special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck," will be given again,

directly after the clinical course. Simon Jesberg, M.D., and Professor S. A. Crooks, anatomist, will conduct this course.

The cadaver course will begin at the conclusion of the clinical course, on January 29, and will carry into the following week—thus avoiding any conflict with the didactic lectures and the regular work of the clinical course. Twenty cadavers are available. This course is restricted to 40 members—two to each table. The fee is \$50.00. In order to register for this special course, kindly send \$25.00 when registering for the clinical course and pay the other \$25.00 at the opening of the course.

The fee for the clinical course is \$50.00. The fee for the cadaver course is \$50.00. All those in active military service may enroll for the clinical course without the payment of a fee; and for the cadaver course for the payment of one-half of the regular fee—namely \$25.00.

California Heart Association San Francisco Division

In a dim amphitheater at the University of California Hospital where the murals on the walls depict the progress of surgery since the days when a "surgeon was a dentist," 200 doctors from six states were meeting today to talk over the problems that face the medical profession, mobilized for wartime duty.

And the problems, they agreed, were these:

A "war heart" is the greatest menace that faces a civilian population.

The scarceness of doctors is reaching alarming proportions.

The man on the street must calm down and the skittish race to live 24 hours in every day must be stopped.

Don't call your doctor unless you need him on an essential duty call.

The "red tape" of the Army, which called into service all medical men of what is termed a "fighting age," is cumbersome and binds doctors, vitally needed for civilians, to waiting three months before they can be used on hospitalization cases.

Nervousness Cited

The increase of public nervousness, which leads to "war hearts" is a potential Axis asset, and if not curbed will develop into cardiac disorders the medical profession cannot meet because it doesn't know how.

Those were the startling statements given at the 13th annual postgraduate symposium on heart disease, held in the gray-white University of California Hospital, where men from the sparse areas of Arizona, Nevada, Washington and California mingled with the surgeons and specialists on health from the cities. . . .

Cardiac Expert Speaks

When the assembly, which is affiliated with the American Heart and California Heart Associations, opened yesterday, Dr. T. Duckett Jones, nationally-known expert on cardiac disorders, professor at the Harvard Medical School, warned sternly that "while the public is more tolerant today than a few months ago, it must realize that 100 per cent of intellectual consideration is worth 100 per cent of medical care."

"Schools are the greatest source of localities that cause the spread of streptococcus infections which lead to cardiac disorders," he said, nodding his head for emphasis. "If parents would only realize that it is better to keep a child who is coughing out of school and if the schools only realized that thinking is more important than attendance—there's the answer to health."

An expert on rheumatic fever, which constitutes one-third of all cardiac diseases and is particularly prevalent in San Francisco among children, Dr. Jones told the

assembled surgeons in the theater of the hospital that "this is our greatest killer and the only answer rests in adequate housing conditions, where each patient may be alone for the rest and quiet that is necessary for cure.

Must Take Rest

"Public nervousness is increasing due to uncertain conditions," he said, "but must be stopped by the individual taking a few hours of rest or else we face a population that is jitterish and vulnerable to heart rheumatism that results from that condition."

He said he had noted a particularly noticeable increase since the war broke out and urged that the "problems of the heart be met by community action."

The meetings began yesterday and will continue today and tomorrow, all devoted to technical clinical discussions of heart ailments, and held under the direction of Dr. J. K. Lewis, chairman, Dr. Dorothy Atkinson, Dr. Charles A. Noble, Marjorie Edwards, and others of the Heart Committee.—San Francisco News, November 6.

Mental Hygiene for Adults in War and Peace

The University of California Extension Division announces a course in Mental Hygiene for Adults in War and Peace, given by Dr. Jacob S. Kasanin and Dr. Herbert E. Chamberlain. The course embraces a discussion of the adult's problems of mental hygiene and personal morale in time of national emergency, and his adjustment to the great issues of the war crisis; special emphasis on personal mental hygiene, the understanding of neuroses, a discussion of the neurotic personality of modern times, and various tangible methods of treatment. Course will be illustrated by case material drawn from clinical practice. Students may prepare their own personality studies, which will be discussed later with one of the instructors. For information, address Registrar, 301 California Hall, Berkeley.

COMMITTEE ON INDUSTRIAL PRACTICE

Extension of Industrial Health Activity Under Wartime Conditions

The War Participation Committee of the American Medical Association recently requested the Council on Industrial Health to develop a plan which would enable the medical profession to contribute more directly to industrial health activity in small industrial plants. *This step was taken in full realization of the dwindling number of physicians who would be available to supply this extended service.* The action stems from statements made by Paul V. McNutt, Director of the War Manpower Commission, before the House of Delegates of the American Medical Association last June in Atlantic City, said:

"The American Medical Association's Council on Industrial Health and Dr. Selby's Committee on Industrial Hygiene, Health and Medicine have aided in the establishment of many industrial medical services. They have helped to create educational programs to train physicians for such services."

"But for the most part that development has been directed to large plants. There is no well recognized plan as yet for the small plant. The more general recommendation of 'coöperation with local practitioners' is not enough. It has not produced results."

The Council on Industrial Health has regarded the small industry problem as a complicated one, calling for action under three principal headings:

1. Establishment of a means for public information

about the benefits of industrial health service.

2. Improved industrial medical education, both before and after graduation.

3. Improved committee organization in the state and county medical associations for aggressive leadership in all aspects of industrial health service.

The Council on Industrial Health of the American Medical Association, 535 Dearborn Street, Chicago, will furnish information to interested physicians.

Twentieth Anniversary of the Industrial Section of the Los Angeles County Medical Association

Twenty years ago, the Industrial Section of the Los Angeles County Medical Association was organized to maintain a high standard in industrial and surgical work; to promote the welfare of the industrial employed and to harmonize the relationship of the employee, the employer, the insurance carrier and the Industrial surgeon.

Through the medium of war, Industrial Medicine and Surgery have now taken their proper place of prominence among the specialties. As a specialty, Industrial Medicine began its existence as an orphan of medical practice with no mother's hand to guide it. Southern California gave this orphan two unusual opportunities for development: first was the unique industrial field, and second, the early organization of the Industrial Section of the Los Angeles County Medical Association.

Industrial practice had for its embryo the company doctor or plant physician. As such, the doctor's experience was confined to a limited industrial field consisting only of those injuries and exposures peculiar to his one plant. This was not so in Southern California. Here, until recent years, we had few large industries. Our industrial field was composed of innumerable small employers, too small to afford a plant physician.

With the advent of the Workmen's Compensation Law, these small employers required some type of medical service. Progressive members of our profession set up their own conveniently located emergency hospitals to serve these small industries. As a result of this situation the experience of the industrial doctor in Southern California has not been of limited nature but has covered a broad industrial field rich in clinical material representing a good cross section of industry in general.

The second favorable factor in development was the organization of the Industrial Section of the Los Angeles County Medical Association in the year 1921. For the past 20 years the monthly scientific programs of this group have been organized and arranged to present a continuous postgraduate course on industrial medical and surgical education.

In 1929, it began the publication of these programs in printed form which made the course available to industrial doctors outside the metropolitan area. This spread the membership beyond Los Angeles County and blanketed all of Southern California. This organization represents the largest active group of its kind in the United States.

These unusual factors have contrived to place the Industrial Specialists of Southern California among the finest in the world and have especially prepared them to meet the emergency of the great industrial war effort now under way.

FLOYD THURBER, M. D., Secretary.

The measure of a happy life is not from the fewer or more suns we behold, the fewer or more breaths we draw, or meals we repeat, but from the having once lived well, acted our part handsomely, and made our exit cheerfully.

—Lord Shaftesbury, *Characteristics*. Vol. i, p. 316.

COMMITTEE ON MEMBERSHIP

The weekly report on membership of California Medical Association, as of date, October 10, 1942, gave the following figures:

Total members for year, 1942: (inclusive of 1056 in military service), is 7013.

New members in 1942, is 468.

(In 1941 there were 6789 total members; 440 new.)

Number of 1941 members who have not paid 1942 dues, is 244.

Of additional interest are the statistics outlined in the table below, for which request was made to the American Medical Association. (Note. Tabulation on present membership enrollments has not been made in recent months.)

In the appended list, the California Medical Association is represented by the Los Angeles and San Francisco County Medical Societies.

(COPY)

TENTATIVE LIST AND FIGURES

List of 20 Largest Component County Medical Societies of the American Medical Association

<i>Name</i>	<i>Number Members</i>
1. New York County Medical Society.....	5,968
New York City, New York	
2. Chicago Medical Society, Chicago, Illinois.....	4,194
3. Kings County Medical Society.....	2,645
Brooklyn, New York	
4. Los Angeles County Medical Society.....	2,297
Los Angeles, California	
5. Philadelphia County Medical Society.....	2,203
Philadelphia, Pennsylvania	
6. Suffolk District Medical Society.....	1,735
Boston, Massachusetts	
7. Wayne County Medical Society.....	1,571
Detroit, Michigan	
8. Allegheny County Medical Society.....	1,386
Pittsburgh, Pennsylvania	
9. St. Louis County Medical Association.....	1,111
St. Louis, Missouri	
10. Academy of Medicine, Cleveland, Ohio.....	1,107
11. Baltimore County Medical Association.....	905
Baltimore, Maryland	
12. San Francisco County Medical Association....	880
San Francisco, California	
13. Erie County Medical Society.....	849
Buffalo, New York	
14. Essex Medical Society, Newark, New Jersey...	845
15. District of Columbia Medical Association....	781
Washington, D. C.	
16. Milwaukee County Medical Society.....	751
Milwaukee, Wisconsin	
17. Academy of Medicine of Cincinnati.....	711
Cincinnati, Ohio	
18. Indianapolis Medical Society, the Medical So- ciety of Marion County, Indianapolis, Indiana..	575
19. Jackson County Medical Society.....	566
Kansas City, Missouri	
20. King County Medical Society.....	521
Seattle, Washington	

COMMITTEE ON MEDICAL ECONOMICS

Compulsory Health Legislation

When army doctors or nurses are mustered out of the ranks they may not recognize their old professions.

A junta of crusading physicians, welfare workers and federal bureaucrats is determined to establish a new type of socialized medicine. Equally resolute conservatives are trying to block the scheme which they assert was "made in Germany." Cool heads hope a modified form of group practice, somewhat similar to the Mayo brothers' plan, will be the eventual compromise.

The reformers forecast the doom of the present Robin Hood system, in which a surgeon operates on the poor in the hospitals without charge because he mulcts the rich. They argue the wealthy class is vanishing and ordinary incomes are depleted by taxes. Private charity cannot support free infirmaries. This condition requires a state service embracing nearly all patients.

Their blueprint designates one big local health center for each 100,000 population, absorbing current school, maternity, child welfare and other clinics. Physicians will be paid standard salaries based on seniority and responsibilities and will be granted pensions. They will have access to district hospitals, convalescent homes and consultant specialists. Universal insurance contributions may underwrite the Utopia or Uncle Sam will foot the bill—as usual.

The idea of a paternal ruling body paying for collective therapeutics originated with Bismarck as a counter measure to the program of the German Socialists and a means of supplying his factories and armies with "healthy human animals." Lloyd George, when chancellor of the exchequer, adopted the project in Britain when hygienists told him the exploiters of the industrial revolution had left the Cockney a worse physical specimen than the Australian bushman.

The advance of American medical science in the last fifty years has been phenomenal. But as diagnostic resources increased the costs of hospitalization also soared. Illness became a rich man's luxury. Welfare theorists campaigned for mass healing financed by associations or the federal treasury. Critics contend that wholesale doctoring is extravagant because organizational red tape wastes a medico's time. They infer a regimented robot is not so inclined to give personal attention as is the general practitioner who has known the ill man for years.

Conservatives offer a substitute arrangement of a less radical nature in which a pool of specialists treat cases at reasonable fees. Care is given to the underprivileged at low rates in a manner which does not destroy the rôle of the family physician. The profession itself intends to be at the helm of this coöperative movement and not surrender control to the politicians or the air castle builders.

Insurance People Oppose Compulsory Disability Plan

Chicago, Illinois.—Proposals of compulsory disability insurance, to be financed by further pay-roll taxes on employers and employees, have led the setting up of a new organization here to oppose the plan.

The objectors enlisted in this counter-move consist of insurance people. They have taken over the name and functions of the old Insurance Economic Society.

The Society will confine its work to research and publication, and will avoid lobbying, its sponsors announce. Facts intended to show the undesirability of government disability insurance will be presented in readable form in pamphlets.

These will be distributed chiefly through the State units of the Society to men and women in the insurance business, to other groups such as doctors and dentists, and to other individuals who may be interested.

Informed Public Opinion

Then, when the issue comes up in Congress, there will

be an informed public opinion on the subject, it is hoped by the Society.

At present there is a wide lack of information as to what compulsory disability insurance is and what its adoption in this country would probably mean, it is said.

State disability insurance is the making of cash payments, usually a percentage of wages lost, to workers during illness which did not arise from the nature of their employment. Accident or illness growing out of employment is a different system, known as workmen's compensation insurance.

Original Form

Compulsory disability insurance was the original form of sickness insurance upon its introduction in Europe.

If disability insurance should be voted by Congress, it would be used as the entering wedge for compulsory sickness insurance in the United States, leaders of the Insurance Economic Society believe.

Revival of the Insurance Economic Society was brought about by Harold R. Gordon, executive Secretary of the Health and Accident Underwriters Conference. This conference, composed of companies writing health and accident insurance, has no connection with the Insurance Economic Society, Mr. Gordon explained, but many of its members are also members of the new organization.

The Insurance Economic Society was originally established in 1917, when there was agitation for enactment of health insurance by the States and bills for that purpose had been introduced in a number of legislatures. Organized by insurance men, its activity continued until 1920, when the movement for State laws subsided.

But last winter, when President Roosevelt proposed expansion of the social security program of the Federal Government to include disability insurance and hospitalization payments, some insurance men saw a need for renewing efforts. The Insurance Economic Society was inactive, but its trustees still held office, and they were willing to allow the name of the organization to be used by the present organizers.

Committees in 40 States

In the last few months, committees in 40 States have been set up and beginnings have been made for the organization of the remaining eight. The headquarters staff in Chicago will be enlarged in the near future.

The insurance society offers a number of specific objections to federal disability insurance from its standpoint. These include the following:

1. The cost of a federal program would be excessive.
2. It would eventually eliminate the private accident and health insurance business and prove an entering wedge for socialization of most forms of insurance.
3. It sets the cart before the horse by first establishing a plan for cash benefits for disability instead of a program of accident and sickness prevention, so much needed in our war production effort.
4. Any new funds collected from the pay rolls of workers should be spent solely to defray the cost of the war. This is no time to experiment with a socialistic theory.
5. It is a stepping stone to socialized medicine and governmental control and regimentation of our present hospital system.

Enlarging upon its charge that disability insurance would lead to socialized medicine, Mr. Gordon declared that in foreign countries most of the systems of socialized medicine began with cash benefits only.—*Boston Christian Science Monitor*.

Temporary Licenses to Practice the Healing-Art in the District of Columbia.—H. R. 7493, introduced by Representative Randolph, West Virginia, August 17,

and pending in the House Committee on the District of Columbia. A bill to amend an Act entitled "An Act to regulate the practice of the healing-art to protect the public health in the District of Columbia," approved February 27, 1929.

Comment.—This bill proposes to authorize the Commission on Licensure to issue temporary permits to practice the healing-art in the District of Columbia. Such permits will be valid for a period of one year and may be renewed for a similar period. All temporary permits, the bill provides, will automatically terminate six months after the end of the present war. Applicants for such permits must submit satisfactory proof to the Commission that they are over twenty-one years of age, of good moral character, and have had "sufficient professional training and experience to warrant the issuance of said permit." The Commission will be given authority to suspend or revoke any temporary permit on evidence showing to the satisfaction of the Commission that the holder has been guilty of professional misconduct or is professionally incapacitated or has been convicted of an offense involving moral turpitude. . . .

Chiropractors and the United States Employees' Compensation Act.—The Tolan bill, H. R. 1052, was favorably reported by the House Committee on the Judiciary, July 9. It is now pending on the Union Calendar of the House of Representatives. Bills on that Calendar may be brought up for consideration under a special rule approved by the House Committee on Rules.

The sponsor of this bill, Representative Tolan of Alameda County, California, who is also a member of the House Committee on the Judiciary, reported the bill on behalf of the Committee. The Committee report (H. Report No. 3235) justified favorable action on the bill in the following language:

"The effect of the bill as amended is to make available to Federal employees coming within the provisions of the United States Employees' Compensation Act the services of chiropractic practitioners licensed by State law and within the scope of their practice as defined by State law as osteopathic services were made available under the act of May 31, 1938 (Public, 566). Seventy-fifth Congress. . . .

"The general purpose of H. R. 1052 is to so amend the existing law as to make it possible for the United States Employees' Compensation Commission to permit injured or disabled Federal employees coming within the United States Employees' Compensation Act to be treated by chiropractic practitioners as well as by medical doctors (generally characterized and commonly known as M.D.'s) and osteopathic practitioners, and to permit such injured or disabled employees to be treated in chiropractic hospitals, as well as in hospitals conducted by medical doctors (M.D.'s) and osteopaths. . . .

Medals for Volunteers Who Served in Trench-Fever Experiments.—H. R. 7499, introduced by Representative Lane, Massachusetts, August 20, and pending in the House Committee on Military Affairs. A bill to recognize the high public service rendered by soldiers who volunteered and served in trench-fever experiments in the American Expeditionary Forces.

Comment.—This bill would authorize the President of the United States to issue an appropriate medal and ribbon to be awarded to eighty-one named members of the armed forces of the United States during the World War who, in the interest of humanity and science, acted as voluntary subjects for experimentation during the trench-fever investigations in France.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (88)

Alameda County (2)

Cecil C. Cutting, *Oakland*

Frederick A. Pletta, *Mare Island*

Kern County (1)

Murray Westerbeck, *Bakersfield*

Los Angeles County (66)

Fred E. Abbott, *Compton*

Irving E. Benveniste, *Los Angeles*

George E. Bien, *Culver City*

Frederick H. Blanchard, *Los Angeles*

Jay H. Blanchard, *Long Beach*

Frederick E. K. Clarke, *Santa Monica*

Edwin Cobb, *Los Angeles*

William C. Custer, *Los Angeles*

Donald John Davenport, *Downey*

Hugh Howard Ditto, *Los Angeles*

Harriet B. Farnham, *Glendale*

Charles E. Fitzgerald, *Long Beach*

Herman J. Fulco, *Los Angeles*

J. H. Gifford, *Los Angeles*

Harry A. Goodman, *Venice*

Antony J. Greco, *Los Angeles*

Carl V. Green, Jr., *Los Angeles*

Louis Gries, *Maywood*

Alfred Norman Hanson, *Los Angeles*

Thomas Lindner Harris, *Los Angeles*

Richard F. Hauck, *Los Angeles*

Donald Quimby Heckel, *Glendale*

Raymond Merrill Hill, *Los Angeles*

Gertrude Turner Huberty, *Los Angeles*

Franklyn H. Johnson, *Los Angeles*

George William Jones, *Pomona*

Elise Jorgensen, *Los Angeles*

Reuben Louis Kaufman, *Studio City*

Norris Curtis King, *Los Angeles*

Eugene Robert Koch, *Burbank*

Edwin George Lee, *Downey*

Samuel S. Mathews, *Inglewood*

Armas Manning, *Los Angeles*

Alfred G. Nast, *So. Pasadena*

Don Paul Nebeker, *Los Angeles*

Robert Dale Nethery, *Covina*

Millard P. Olney, *Los Angeles*

Charles T. Poulson, *Inglewood*

William Kent Pudney, *Encino*

James Archibald Ramsay, *Santa Monica*

Richard Robert Ronan, *Los Angeles*

Paul Laurence Saffo, *Inglewood*

Peter Joseph Scherr, *No. Hollywood*

H. Wright Seiger, *Santa Monica*

William Walter Shaffer, *San Marino*

Merle Anthony Smith, *Lennox*

Seymour A. Spungin, *Wilmington*

Frank W. Stewart, *Long Beach*

LeRoy Powell Strayhorn, *Los Angeles*

Mary Elizabeth Tiffin, *Los Angeles*

M. Charlotte Van Gundy, *Beverly Hills*

Ralph F. Waddell, *Glendale*

Henry J. Weedn, *South Gate*

Charles Francis Werts, *Los Angeles*

Elden Glenn Wood, *Los Angeles*

Placer-Nevada-Sierra County (1)

Wallace B. Hardie, *Dutch Flat*

San Diego County (1)

L. L. Laugeson, *San Diego*

San Francisco County (10)

Harry Alton, *San Francisco*

Carl E. Anderson, *San Francisco*

Wm. Sayre Cary, *San Francisco*

Lazarre John Courtright, *San Francisco*

Doris Emerson, *San Francisco*

Anthony A. Ferrante, *San Francisco*

Michael John Hogan, *San Francisco*

Thomas L. Magee II, *San Francisco*

James W. Shumate, *San Francisco*

Louise A. Yeazell, *San Francisco*

San Joaquin County (1)

Donald C. Harrington, *Stockton*

San Mateo County (1)

Paul S. Wagner, *Redwood City*

Solano County (4)

Clark T. Alexander, *Vallejo*

Samuel S. Carlson, *Vallejo*

William O. Dockendorff, *Manor*

Harold M. Gibbons, *Vallejo*

Stanislaus County (1)

G. G. Sweeley, *Hughson*

Transfers (1)

Joseph Patrick O'Connor, from *San Bernardino County* to *Los Angeles County*

In Memoriam

Crook, Harvey Willis. Died at Bishop, August 2, 1942, age 69. Graduate of California Eclectic Medical College, Los Angeles, 1914. Licensed in California in 1914. Doctor Crook was a member of the Inyo-Mono County Medical Society, and the California Medical Association.

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Mattison, Samuel Jones. Died at Pasadena, October 3, 1942, age 67. Graduate of Northwestern University Medical School, Chicago, 1904. Licensed in California in 1904. Doctor Mattison was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARIES

Samuel Jones Mattison

1875—1942

Samuel J. Mattison, 67, a leader in Southland medical circles, died at his home at 520 Bellmore Way, Pasadena, on October 3, 1942.

He had been ill for four months but was believed to be recovering, and was about to resume his work when his sudden death occurred.

Dr. Mattison was born in Annapolis, Md., and was a graduate of both Georgetown and Northwestern Universities.

He came to Southern California 40 years ago and for many years was a member of the surgical staff of the Los Angeles County General Hospital. Up to the time of his death he was a staff member of the Huntington Memorial Hospital in Pasadena. He served overseas as a captain in the Medical Corps in the first World War.

† For roster of officers of component county medical societies, see page 4 in front advertising section.

William Sidney Bowers

1894—1942

In the recent sudden death of William Sidney Bowers, M. D., Los Angeles lost a man who though just entering middle age, was one of the earlier and better recognized of our pediatricians. After securing his M. D. at University of Southern California in 1919, Dr. Bowers spent three years as a Teaching Fellow in Pediatrics at the Mayo Foundation in Rochester and Minneapolis, Minnesota, gaining an M. S. in this specialty in 1922. His practice has been continuous since then, during which time he was active in the affairs of the Children's Hospital, the Southwest Pediatric Society and many other child welfare groups.

His many patients and friends mourn the untimely passing of a fine person and a beloved doctor.

EDWIN F. PATTON, M. D.

**Eric Liljencrantz**

1902—1942

Word of the death of Commander Eric Liljencrantz, Stanford scientist and authority on aviation medicine, in a Navy plane crash on November 5, 1942, at Pensacola, Florida, was received in San Francisco on November 7.

Engaged in secret research work for the Navy, Commander Liljencrantz was killed when the plane in which he was riding failed to pull out of a dive.

A graduate from the Stanford school of medicine in 1929, Commander Liljencrantz studied abroad and became a faculty member at Stanford in 1931. He specialized in surgery, x-ray and control of cancer. He joined the Naval Reserve when he began practice and carried on research in aviation medicine, serving with Pan American Airways. He was called to active duty by the Navy in 1940.

He is survived by his widow, the former Thais Scott of Oakland, and a daughter, Francora, 17, both of Washington; and his father, Dr. Guy Liljencrantz of Oakland.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM...Asst. Chairman on Publicity

County Auxiliary News Items

On September 11, 1942, Mrs. F. G. Lindemulder, State President, and her Board met in the Rio del Mar Club near Santa Cruz. Since the club is situated in the heart of the military dim-out zone, no evening entertainment was planned.

The business meeting was called to order at 10:30 a.m. After Mrs. Lindemulder's opening talk, even the most dubious of the Board members and County presidents were convinced of the necessity of carrying on the various projects, and accomplishing the Auxiliary aims which are the same, but have become so much more important in time of war.

At noon the President and her Board were honored at a luncheon in the Club. Mrs. O. C. Marshall, Santa

Cruz County President, presided. Special guests were the wives of the Medical Officers stationed at Camp McQuaide. The luncheon tables were beautiful with a profusion of pastel begonias. Following luncheon, a program of music was furnished by Mrs. Norman Sullivan and her young daughter.

During the afternoon business session, Miss Ethel O'Brien, Public Health Field Representative, talked on the Basic Science Act. Tea served by the gracious hostesses of Santa Cruz County concluded the day's activities.

The October meeting of the Alameda County Auxiliary was held on Friday, October 16, at the Claremont Country Club. Following luncheon, Mrs. Gerald Fitzgerald, Director and Production Chairman of East Bay Children's Theatre Association, entertained with a group of readings. "Interlude of Spanish Music" was played by a trio of talented musicians. Mrs. A. A. Alexander and Mrs. J. Randolph Sharpsteen were hostesses.

At the request of the Medical Society, Mrs. T. Floyd Bell, Auxiliary President, and her committee have been conducting a letter campaign to further the passage of the Basic Science Act.

With dim-out laws, new speed laws, tire problems, and nature's curtain of fog acting as ushers, eight members of the Woman's Auxiliary to the Humboldt County Medical Association met at the home of Mrs. Lawrence Wing at 8 o'clock on October 5.

Mrs. John S. Chain, Jr., president, called the meeting to order. During the evening five committee chairmen were elected.

The week beginning November 9 was chosen as the time when members would act as hostesses at the Eureka U. S. O. Center. Mrs. Joseph Walsh was appointed Chairman of Arrangements.

Orange County's first meeting of the year was held at the home of Mrs. Harry G. Huffman. This was a Public Relations meeting, and representatives from all of the women's groups were present.

Mr. Ben H. Read, Executive Secretary of the Public Health League of California, and his companion speaker, Mrs. Walter Egan Toole, addressed the meeting.

San Francisco's opening Fall meeting was held on September 15. Dr. Genevieve Gaffney, Vice-President of the San Francisco Medical Society, gave the welcoming address. Mr. M. H. Stewart, Director of Public Information and Instruction of the San Francisco Defense Council, spoke on the San Francisco plan for the care and protection of the public in case evacuation became necessary. Mrs. Raleigh Burlingame, newly-elected president, presided and introduced the speakers.

Mrs. Burlingame, with the assistance of Mrs. Morris Gordon, Legislative Chairman, has been active in organizing an educational program in support of the Basic Science Act, Proposition No. 3.

On Thursday evening, September 4, the Marin County Auxiliary held a dinner-meeting at the Blue Rock Hotel in Larkspur. The president, Mrs. Rodney Hartman of Mill Valley, presided.

Miss Ethel O'Brien, of the Public Health League, gave a talk on the Basic Science Initiative. Mrs. Robert Furlong of San Rafael, who is Chairman of the Federated Women's Clubs of Marin County, talked on

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

the Blood Bank and explained the methods used to secure donors.

Mrs. Alex Miller, Marin County Commander for the Field Army of the American Society for the Control of Cancer, reported that, to date, \$125 has been collected in Marin County, and that contributions are continuing.

The Woman's Auxiliary to the San Mateo County Medical Society, under the leadership of Mrs. J. Garwood Bridgman, has been active in war work all through the summer months. The members have made sheets for the Civilian Defense Emergency Station. Others have handled the Canteen work for the San Mateo Blood Bank. Several Auxiliary members have been directly responsible for organizing the San Mateo County Blood Bank.

Women's part in war efforts was discussed at a meeting of the Fresno County Medical Auxiliary which was held in the women's lounge of the University Sequoia Club on October 6. The President, Mrs. R. W. Dahlgren, presided.

The work of the various war agencies was discussed by the following members: Mrs. Guy Manson, Mrs. Chester Vanderburgh, Mrs. A. E. Anderson, and Mrs. Walter Avery.

Solano County Medical Auxiliary, with a membership of only thirteen, deserves special mention for its outstanding work in the establishing and operating the Vallejo Civilian Blood Bank. Under the leadership of Mrs. Brownlee Perkins, these Auxiliary members, with the assistance of the Medical Society, Nurses' Association and prominent members from the community, have financed and operated this Blood Bank for the past six months. During the month of April over one thousand people, who were willing to give their blood to the Bank, were signed up by members of the Auxiliary.

CALIFORNIA PHYSICIANS' SERVICE†

C.P.S. is beginning to solve the problem of medical care for workers residing in houses constructed by the Federal Public Housing Authority. The medical problems that these projects have created have had nationwide discussion, and have been pointed out repeatedly to the medical profession by statements from Paul McNutt and Surgeon General Parran.

There is a westward migration of war workers to California. It is estimated that there are approximately 250 000 such workers here, many of whom have crossed the borders. It is also estimated that approximately 150 000 of these workers will be migrating within the State from place to place. The health hazards of such a movement are, of course, apparent to all.

Housing Projects

To stabilize this labor, the Federal Public Housing Authority has constructed housing projects in areas where the need seemed greatest. Most of these have been built in new areas, which formerly had only small populations. This meant that the number of doctors in

the community, and the hospital facilities, were not geared to take care of additional crowds of persons. The concentration of large numbers of people from all sections of the country in these housing projects naturally creates an actual and potential health hazard of quite sizeable proportions. Uncontrolled, they could easily be the center from which epidemics might begin and spread through the community. Adequate medical care for these people is essential, not only from the standpoint of public health hazards that are evident, but also from the point of view of reducing loss of man-hour time, and increasing the morale of these communities. The specter of the war worker coming from distant parts, not knowing any of the medical facilities of the community and being faced with an acute illness, is a hazard which any of these families may face at any time. The confusion and the probable loss of life can very well be of such concern as to undermine the working efficiency and the morale of our war workers.

The need for medical care has been evident to those physicians who are practicing in the communities and many discussions have been held by various physicians. As time has gone along, these physicians have become busier and busier, and have little leisure to devote to problems of this magnitude. The same is true of the County Societies which are made up of these same busy physicians, and even if some plan had been suggested by them, once they had assumed responsibility, the machinery for carrying out all the complexities of a medical-care program would have been too much.

The California Physicians' Service has been considering the problem for several months, and has offered a plan to the Federal Public Housing Authority to meet this need. In approaching the subject, several fundamental factors had to be considered:

1. How to conserve the time of the already busy physicians.
2. How to bring in more physicians to care for the increased population.
3. How to relieve the load on the already overburdened hospitals.

Linda Vista Project

In May of 1942, C.P.S. experimented with a plan in the Linda Vista Project in San Diego. The entire responsibility for developing a medical-care program was assumed by C.P.S. Through its sales force, an attempt was made to enroll families throughout the project in a prepaid medical-care program. When a sufficient number had enrolled and adequate financing was in sight, then doctors and nurses would be placed on the project to serve the residents.

In this experiment it was found that the sales cost was excessive, and the response of the people to prepaid medical care was lacking. For this reason, the growth of the plan has been slow. Nevertheless, by placing two additional physicians in a community of some 12 000 persons, the emergency load upon the San Diego doctors was relieved to a great extent. The people residing on the project, even though they had not signed up as members of C.P.S., knew that medical care was available to them. The Linda Vista experiment in this respect has been successful, but there were many shortcomings that became evident as time went along.

When the need for medical care became apparent in other projects throughout the State and C.P.S. was again consulted as to ways and means of meeting the situation, it was felt that some modifications of the original experiment should be made. For this reason, members of the C.P.S. staff have been in constant

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of non-profit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

consultation with the staff of the Federal Public Housing Authority and with representatives of the United States Public Health Service. It was felt that there was a joint responsibility on the part of all three agencies concerned, and that coöperation among all should be evident in the phases in which each was most effective.

New Plan

The new plan which has been decided upon for housing projects now includes the responsibility of the Federal Public Housing Authority to enroll, on a voluntary basis, members in C.P.S. on a prepaid basis. An arrangement with the Housing Authority to collect dues of those who have elected to enroll, when rent is paid, greatly simplifies the plan and makes more certain its continuation. These two fundamental factors will be of great assistance in achieving the objective of medical care for the majority of people in these projects. C.P.S. will then concern itself with supplying necessary physicians and nurses, and, in conjunction with Blue Cross Hospital Associations, arrange for necessary hospitalization.

Marin City Procedure

An example of how this new plan is working may be cited from the experience in the new housing project in Marin City. This project is located in the southern tip of Marin County, contiguous to a new shipbuilding plant. In this particular area, there are only two physicians, and no hospital closer than fifteen miles. However, in this community suddenly will appear approximately 7,000 persons residing on the project alone. It is evident that such a situation would create an extreme medical problem. As the project was progressing and people were moving in, C.P.S. first placed a nurse there to direct patients to local physicians. Later, more nurses were added, and finally physicians were placed on the project. In the very first few weeks of covering the medical needs there were cases of strangulated hernias, pneumonia, fractures, injuries, influenza, and a potential epidemic of tonsillitis, along with the general run of medical and surgical ailments. Prompt and adequate medical care was obtained for all.

The addition of this medical personnel to the community is meeting the need which is evident to all from a medical viewpoint. In relation to hospitalization, the use of visiting nurses and the instruction of mothers in home-nursing will be important factors in conserving hospital capacities. As the project further develops, there is opportunity for collaboration with local Departments of Health on meeting some of the basic public health needs, such as vaccinations and other epidemiological conditions. There is even the opportunity for some type of medical education and health conservation program. This will give the residents of housing projects a well-rounded medical care program which will successfully solve one of the greatest medical needs yet to appear in this State.

It is an example again of collaboration of the medical profession with the various governmental agencies concerned. It means that the medical profession of this State has been foresighted enough to develop machinery to cope with these problems as part of the medical profession's activities in medical economics. Because of the vastness of this move and its importance, it is becoming increasingly apparent that every physician in the State of California who is in private practice should lend his or her support to the things which C.P.S. is trying to solve for them. The moves that C.P.S. is making are designed to conserve the time of the remaining physicians, and to make the use of their time more effective for the patients they will be seeing. Since it is the plan that consultation work and care for hospitalized cases will be referred from these proj-

ects to local physicians when the medical need is apparent to the physician on the project, it is necessary that all physicians in the State be members of California Physicians' Service, in order that this movement may go forward successfully.

Rural Health Program for Low Income Farm Families Presented at Parley Here

A rural health program for farm families of California, families with a net income of \$2,000 or less, was presented before farm organization leaders and interested county representatives last night and met with apparent, general approval.

Arranged by the Farm Security Administration, the meeting provided a general discussion of a rural health program offered through the California Physicians' Service and Hospital Service of Southern California.

Jamie Robertson, acting Rural Rehabilitation Supervisor for the FSA, and R. W. Pontius, area specialist for the FSA, presided. It was explained that the program had been tried out by the FSA in Northern California and had met with success there. Fundamentally, it was explained, frequent cause of failure of an FSA administered family was a breakdown of the budget because of sickness or accident and adoption of an insurance for the low income group farm families resulted in maintaining budgets as outlined by FSA supervisors.

Bernard B. Berkov, representative of the California Physicians' Service, presented the plan and answered questions during a round table discussion which followed.

Dr. Frank Guido, secretary of the Tulare County Medical Society who attended as an observer for the Medical Society, explained that the California Physicians' Service was a nonprofit organization organized by the California Medical Association, and that 80 to 85 per cent of physicians and surgeons are practicing members. Personally he favored the plan and while he did not speak for the Society, the plan is believed acceptable to the Tulare County Medical Society. Dr. Guido pointed out that the plan offered the member choice of a physician of the member's own selection.

4,000 Families

Discussion brought out that there were an estimated 4,000 farm families in Tulare county under the \$2,000 income (based on the 1941 census) and that in the case of numerous farm families of this type no appreciable net income rise could be expected this year. Some 250 to 300 Tulare county farm families operate under the FSA, but the program, as advanced, would permit extension of the service to all rural families within the bracket through creation of local Farmer Health Associations. . . .

As outlined, the plan is designed to meet common health problems of California farmers and their families on a coöperative basis, providing prepaid medical care and hospitalization for an annual cost. . . .—Visalia Times-Delta, October 15.

* * *

Farm Health: California Is Helping Wipe Out a Specter of Sickness

The grim specter of sickness and doctor's bills, major cause of financial disaster for America's farmers, is being wiped out for farmers in California.

A new State-wide program of prepayment, developed by farmers and physicians, is to be placed in full operation early next month.

Farmers in the low-income groups—and most farmers are so situated—will be able to get the best medical, surgical and hospital care for themselves and their families at a cost of about \$10 to \$20 a year per person.

Any farm family in California with a net income of \$2,000 or less a year can join.

May Obtain Loans

For mild chronic ailments those over the age of 19 will receive not more than three weeks' intensive care, plus monthly checkups. Those under 19 receive full care for chronic ills.

The farmer must pay \$1.50 for his first home visit required for each illness.

The farmer must pay for drugs up to \$5 prescribed for any illness, but the C.P.S. will pay the rest.

For childbirth, the C.P.S. provides all medical services and in addition hospitalization up to \$25.

No provision is made for treatment of mental disorders, drug addicts, chronic alcoholism, eye refractions, injuries or diseases handled by Workmen's Compensa-

tion or Employers' Liability Law, or any services available from governmental agencies.

Furthermore, it was announced, when farmers are unable to find the money to join the new program, they may, if eligible, secure a special loan from the Farm Security Administration. The Government doesn't want farmers to get sick, and it wants them to get cured in a hurry.

Details of the new program were disclosed here yesterday by the Farm Security Administration and the California Physicians' Service.

Most farmers, FSA officials said, can stand bad weather, bad prices and bad labor conditions, but when they get sick—then there's trouble in the farm belt.

Bad health, surveys have shown, is responsible for nearly half the failures of farmers to pay their loans.

Farmers don't have the money to pay doctors, they don't like the double cost of leaving their work to see a doctor in town, and they don't nip illnesses in the early stages.

Furthermore, when illness hits a farm family it can amount to a full and complete catastrophe.

Case Record Given

In one California county, FSA records showed, the "A" family—buffeted by previous bad years—managed to get a government loan to buy a farm.

The family members worked hard, budgeted their expenses to rock-bottom, planned every step of their farm operation, and began to look forward to the day when the loan would be all paid and their acres would be their own.

Then, within a period of seven months, unmitigated disaster struck. Mrs. A., expecting a child, developed pleurisy and had to be sent to a hospital. Her baby was born prematurely and required special medical and hospital care.

Soon a 4-year-old daughter developed whooping cough, and had to have tonsils and adenoids removed, and finally Mr. A. became sick and needed care for a skin disease.

The total bill? It would take \$600 at least—and there would go the farm. The family just didn't have the money to pay both the doctor and the bank.

To do something about families like that—and there are thousands of them every year—farm and medical leaders started six years ago in the East to protect against these unanticipated shocks.

The FSA arranged agreements between its borrowers and groups of physicians to provide a form of prepayment for farmers. In California this system was tried last year in seven counties in the Butte, Sonoma and Monterey areas.

More than 1100 individuals in some 275 farm families were united in these three California areas.

In one year there were 866 new cases of illness among these 1100 people. Their total bill for medical care—doctor's bill, hospital care, x-ray, laboratory, operating room and drugs—was nearly \$12,000.—San Francisco Chronicle, October 11.

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Farm Medical Care Arranged: Rural Health Program Sponsored by USDA

Low income farm families may soon enjoy the advantages of more adequate medical care through the rural health program, sponsored by farm security administration and California Physicians' Service. The program was endorsed yesterday by Santa Clara County USDA war board, Harvey Hansen, its administrative officer announced.

Rural health program is a coöperative plan whereby farm families with low cash incomes can be assured of needed medical, surgical and hospital service.

The medical care will be provided through the California Physicians' Service which is a group of licensed medical doctors working together with coöperatively-minded groups of families and of individuals in an attempt to assure the best of medical care.

The program will be available, at the present time, to all farm security administration borrowers and other farm families in the county whose annual net incomes, for State income tax purposes, are \$2,000 or less.

The rural health program will be announced in detail shortly by Gilbert L. Taggart, rural rehabilitation supervisor for the farm security administration, located in the Burrell Building, in San Jose.

Hansen stated that all farm security administration borrowers will be approached in an endeavor to have them join this coöperative and there will also be a sponsoring group, as well as key men in various communities who will endeavor to make the rural health program available to the largest number of qualified farm families in the county. Farm families as a group,

in the past probably have not been able to avail themselves of the best and adequate medical services, and the present coöperative arrangement is, therefore, considered by the county war board as a step in the right direction, particularly during wartime when it is everybody's duty to keep in the best physical condition.—San Jose Mercury-Herald, September 30.

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Fresno County Farmers Hear Health Program

The medical profession's health program for farm families of California was presented to representatives of agencies having contacts with rural families of Fresno County at a meeting in the Fresno State College last night.

Another meeting will be held November 9th, when organizations represented will report the reactions of their groups.

Under the program, farm families with an income of \$2,000 a year or less will be offered a health insurance program at a maximum cost of \$60 a year.

Speakers Describe Program

The program was outlined by Bernard Berkov of San Francisco, representing the California Physicians' Service; R. W. Pontius, FSA area specialist in the San Joaquin Valley, and W. G. Riedy, chief of the health service section of FSA for four western states.

Among the agencies represented were the Fresno County Farm Bureau, Fresno County Pomona Grange, Fresno County Schools, Agricultural Extension Service, Fresno County FSA and the Production Credit Association.

Pontius pointed out rural areas are being exhausted of doctors because of the needs of the armed services and better financial opportunities elsewhere.

Plan Will Keep Doctors at Home

The speaker said it is possible to keep at least a safe minimum of doctors in the rural areas if they can be assured a considerable group of prospective patients on a paid in advance basis.

Pontius said the program will afford "the most complete medical care offered any group of people in the country under any comparable plan."

Families participating will receive all necessary medical services for acute illnesses or injuries; all necessary medical services for chronic illnesses of minors under 19 years; all necessary medical services for chronic illnesses of persons of 19 years or older for a maximum period of three weeks, plus monthly check-ups thereafter as necessary; all necessary surgical services for minors under 19; similar services for persons 19 or over for illnesses originating after the beginning date of membership; prenatal, delivery and post natal care in maternity cases and all x-ray and laboratory services necessary in connection with the above.

Patient Can Choose Doctor

The members of the group would have the services of the doctors of their choice as listed in the roster of the California Physicians' Service, organized in 1939, and now including a majority of California doctors. One hundred five Fresno County doctors are listed as members.

Hospital care is provided for a period of ten days in each separate illness or in certain cases can be extended to a maximum of twenty-one days on recommendation of the attending physician.

In order to set up the plan here, Riedy estimated it would be necessary, from a sound actuarial standpoint, to organize 70 or 80 per cent of the eligible families in the area.

Pontius indicated the FSA will proceed to organize a group in Fresno County, with its own 350 borrowers as a nucleus, and if farmers represented in the farm bureau, grange and similar organizations are interested, they may join at the same time.—Fresno Bee, October 13.

Erratum.—In the October issue, on page 281, the last paragraph of the text (descriptive of the map illustrating the article by Doctors Swartout and Harvey, on page 232) was jumbled by the printer's make-up operator. The proof submitted to the editor was correct. The final printing was in error. The paragraph should have appeared as follows:

"The correlation between severity of bite and shortness of incubation period was striking throughout the group of secondary cases (twenty dogs in all, bitten by the original rabid animal). The home of the owner of the original rabid dog is shown in the left lower corner. (on Muriel Street almost opposite the figure twenty and the word Compton)."

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a.m., under the title "Your Doctor and You."

In November KFAC will present these broadcasts on dates of November 7, 14, 21 and 28.

The Saturday broadcasts of KECA are given at 10:30 a.m., under the title "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Students and Medical Care:* Have you seen R. S. Aitken's snappy remarks on Medicine Tomorrow, which he addresses to medical students (*Lancet*, 243:235, Aug. 29, 1942)? Maybe you've noted the series on Distribution of Health Services in the Structure of State Government, culminating in J. W. Mountin and E. Flook's Medical and Dental Care by State Agencies (*Pub. Health Rep.*, 57:1235, Aug. 21, 1942).

2. *Chemotherapy:* A. T. Fuller, F. Hawking and M. W. Partridge (*Quart. J. Pharm. Pharmacol.*, 15:127, 1942), report that sulfapyridine and diazine are absorbed from surface wounds at low constant rates, while sulfathiazol is taken in more quickly, and sulfanilamide most rapidly of all. F. R. Bradbury and D. O. Jordon, in discussing surfacing behavior of antibacterial compounds (*Biochem. J.*, 36:287, 1942), suggest that association of such drugs with cells is a function of $-NH_2$ groups and that polarity produced by resonance is a factor influencing activity. E. J. Poth finds succinylsulfathiazol better than sulfaguanidine for bacillary dysentery (*Arch. Surg.*, 44:208, 1942; *J.A.M.A.*, 120:265, Sept. 26, 1942; *J. Lab. Clin. Med.*, in press).

3. *Russian Work Filters In:* T. A. Balaba (*J. Physiol., USSR*, 29:318, 1940), says that thyroglobulin in low concentration stimulates formation of vitamin A from carotene, while other globulins have no such effect, and that minced thyroid does same, but that thyroxin inhibits. A. O. Voinar and M. P. Babkin (*Ibid.*, p. 345), survey action of oxalate on blood potassium, calcium and magnesium. L. A. Crandall, Jr. (*Ibid.*, p. 303), shows that in hungry dogs the liver can furnish 0.5 g glucose/kg/hour. I. A. Pigalev (*Ibid.*, p. 255), indicates variety and degree of biochemical disturbances through body caused by nerve trauma, such as 10 minute electrical stimulation of sciatic.

4. *Greetings to Herbert Evans:* A. C. Crooke and C. J. O. Morris (*J. Physiol.*, 101:217, 1942), revive and improve old California work of A. B. Dawson, H. M. Evans and D. H. Whipple (*Amer. J. Physiol.*, 51:232, 1920), on use of blue tetra azo dye T.1824 ("Evans Blue,"—here's to you, Herbert!) for rapid estimation of plasma volume.

5. *Drugs in Therapy:* E. Simonson and N. Enzer (*J. Indust. Hyg. Tox.*, 24:205, 1942), find that desoxy-ephedrin ("Pervitin"), gives subjective relief from fatigue like "Benzedrin." E. Bulbring and J. H. Burn (*J. Physiol.*, 101:224, 1942), confirm H. Viets and R. Schwab (*J.A.M.A.*, 113:559, 1939), that in treating myasthenia gravis it is better to give ephedrin with prostigmine than to give the latter alone. G. Brownlee, H. W. Bainbridge and R. H. Thorp (*Ibid.*, p. 148), find iron triethanolamine chelidamate a soluble rapidly absorbed iron complex for parenteral iron therapy; it quickly builds hemoglobin, is not excreted in the bowel, though some may pass into urine, but iron ions may give toxic reactions in hypochromic anemia. H. A. Oelkers (*Arch. Exper. Path. Pharmacol.*, 197:193, 1941), reports toxicity of theophylline increased more by combination with ethylene-

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

diamine than with diethanolamine, though both increase its diuretic action; and phenobarbital and theophylline are mutual antagonists.

6. *Odds and Ends*: C. W. Emmcus (*J. Endocrin.*, 3:168, 1942), discusses biochemorphology of estrogens and pro-estrogens related to stilbene and triphenyl ethylene. M. G. Eggleton gives neat study (*J. Physiol.*, 101:172, 1942), of alcohol diuresis in man, showing urine alcohol 30 per cent higher than blood and diuresis inhibited by post-pituitary. Lot of ideas in K. A. Oster's note on anti-pressor and depressor effects of oxidation products of pressor amines (*Nature*, 150:289, Sept. 5, 1942). G. B. Frost and H. M. Gelly discuss action of mustard gas on skin (*Pharm. J.*, 149, Aug. 29, 1942), while D. Marsh's ideas on war gases appear in *Science* (96:194, Aug. 28, 1942), and in *Time*, Sept. 28, 1942.

Removal Plan for Sick Set.—Plans have been completed, as a precautionary measure, for the orderly removal of 43,000 inmates of nine State hospitals and 15,000 chronic cases from county institutions in the event of enemy action in California.

That fact has been revealed by Thomas F. Clark, State hospital officer of the State Council of Defense. Clark said that in the event removal of State hospital inmates to institutions in the middle-west became necessary, an excess of 50,000 hospital beds would be available immediately for war casualties.

Clark added that he wanted again to reassure relatives and friends of State hospital inmates that the plan for the removal of such inmates to middle-western institutions has been developed only as a precautionary measure.

Irwin Blood Bank Offers New Service for Babies.—A "Baby Blood Bank." . . .

It's a new and unique feature of the Irwin Memorial Blood Bank of the San Francisco County Medical Society.

Special baby-sized bottles of specially-prepared baby-strength blood are now being sent to infants requiring transfusions in San Francisco Bay Region hospitals, the San Francisco County Medical Society's Blood Bank Commission disclosed today.

The innovation has a double purpose—to conserve blood and to provide a higher quality service to infants, the Blood Bank Commission explained.

Formerly, when the adult-size full pint bottle of blood was furnished babies, about half the blood was not required, and was often wasted. Furthermore, the anticoagulant concentration of sodium citrate used in adult transfusions wasn't always entirely satisfactory for babies.

Now, the special half-pint bottle with a lower anticoagulant concentration is found to be just right for the "half-pint" patient.

Calls for "baby blood" are increasing all the time, the Blood Bank Commission revealed. They are received daily. It isn't that San Francisco babies are less healthy than they used to be; it's just that there are so many of them, and the use of blood to prevent emergencies as well as to meet emergencies is becoming more prevalent, the doctors said.

Baby conditions requiring transfusions include birth damage, under-nourishment, anaemia and jaundice.

The Blood Bank Commission pointed out that prospective fathers in the armed services may be confident that their wives and families in San Francisco now have better protection than ever before against conditions requiring blood transfusions.

Blood donated to the Irwin Blood Bank and not immediately required for transfusions is pooled and pre-

served as plasma as a safeguard against an emergency to this city.

Volunteers who can donate blood are urged to make appointments by telephoning Walnut 5600, or address: San Francisco County Medical Society, 2180 Washington St., San Francisco.

California Tuberculosis Association.—"Follow the example of the armed forces . . . Get a chest x-ray!" is the theme of a nation-wide educational campaign to be launched next April by the 1800 tuberculosis associations in the United States.

Funds to finance this campaign, aimed at protecting the productive power of the United States against tuberculosis, will be raised by the 36th annual sale of *Christmas Seals* which opens November 23, 1942. California's 62 tuberculosis associations are taking part in this war work.

Special posters, pamphlets, exhibit material and radio programs have been prepared under the direction of the Committee on Educational Literature of the American Trudeau Society and the Health Education Committee of the National Conference of Tuberculosis Secretaries.

"Sudden growth of war industries has brought armies of new industrial workers and their families to many communities," Kendall Emerson, M. D., managing director of the National Tuberculosis Association, says.

These have not yet become a part of the community pattern. It is essential that the tuberculosis associations, in coöperation with the public health officers and nurses and the medical profession, reach these millions of workers with authoritative health facts and concrete suggestions for health protection.

Medical Board Elects Dr. Percival Dolman.—The State Board of Medical Examiners in Sacramento today elected Dr. Percival Dolman of San Francisco, as president, succeeding Dr. Fred De Lappe of Modesto.

Dr. George Thomason of Los Angeles, was named vice-president and Dr. Charles Pinkham was reelected secretary, his 30th year in that capacity.—San Francisco *Examiner*, October 22.

Adequate Medical Care for Civilian Population.—A great deal of anxiety among the people of this community exists as a result of reports and widespread rumors that there are not enough doctors remaining to take adequate care of the civilian population; that those who remain are often too busy to answer emergency calls. The Los Angeles City Health Department, following conferences with the Los Angeles County Medical Association, wishes to state emphatically that while many medical men have been called into service with the armed forces since the first of the year, there is no need, at the present time at least, for the people of this community to worry about a possible inability to obtain the services of a physician in time of sickness.

It is true that the armed forces already have taken many physicians under the age of thirty-six years and will take many physicians under the age of forty-five before the year is over. The doctors who remain must assume the added work of caring for the patients of those who have left. Until the situation grows far worse they will be able to and will carry that load. However, if the people of this community want to be assured of medical care when medical care when medical care is needed, a definite responsibility is theirs. To insure the services of a physician in times of severe sickness they must know that it is their duty now to conserve the physician's time. This can be done easily in several ways:

1. Do not wait until you are seriously sick before call-

ing your doctor. If, during the day you are not feeling well, call your doctor before nightfall. Doing this accomplishes two important things: it brings your doctor to you at the very beginning of what might become a serious illness, giving him the opportunity of bringing about a speedy correction of the condition in many instances, saving you both time and money. It also saves the doctor from making a night call, thus conserving his energy for the heavy tasks that face him the following day.

2. Do not wait until you are so sick that you cannot go to the doctor's office. Much of the doctor's time can be saved for other patients through the foresight you exhibit going to the doctor's office before you become so sick he has to come to your home.

3. Make a definite appointment with your doctor and keep it. This will save your time and give the doctor more time during this emergency to see more patients who may need his attention just as much, if not more than you do.

There should be no shortage of physicians to care for the civilian population of the city of Los Angeles if the citizens themselves will pay heed to the above advice. It is true that a real emergency exists, but if we all do our part there should be no need for anxiety.—George M. Uhl, M. D., Health Officer.

University of Texas Medical School Vice-President Chosen.—Dr. Chauncey Leake, former pharmacologist of the University of California School of Medicine, was recently appointed executive vice-president and dean of the medical branch of the University of Texas at Galveston, advises the *Austin American*. Dr. Leake succeeds Dr. John W. Spies, who was recently released by the board of regents. Dr. Leake will also have charge of the John Sealy Hospital and the college of nursing.

Dr. Leake has held the chair of pharmacology at the University of California for the past fourteen years. He organized the department, which is now recognized as one of the foremost in the country. At times he has served as dean of the University of California. Prior to his position in California, he was assistant professor of pharmacology in the University of Wisconsin.

En route to Texas from California, Dr. Leake visited medical leaders in Wichita Falls, Fort Worth, Waco, and Austin, conferring with the governor of the State and university officials in the last named city.

Dr. Leake is reported by the *Galveston Tribune* to have in mind the development of a State-wide consultation and diagnostic service along health lines with particular reference to indigents. With regard to the matter of relocation of the medical branch, Dr. Leake stated that in certain special and graduate fields, it may be necessary to use other localities, but the rôle of the medical college at Galveston would be that of leadership. He averred that the contributions from the medical faculty had been of the highest order and excellence. He expressed the view that the University should avail itself of impartial advice on medical matters that may come from medical and health practitioners throughout the State, such as the present advisory committee named by the board of regents, made up of representatives of the medical groups of the State. He is enthusiastic regarding the development of the medical branch of the University of Texas into a great institution of geographic medicine.—*Texas State Journal Medicine*, October, 1942.

Georgia Declares Quarantine on Venereal Disease Cases.—The Georgia Board of Health declared a State-wide quarantine upon all persons suffering with any venereal disease and ordered the detention and treatment of all such persons not receiving medical care.

Violation of the regulations established to enforce the quarantine was made a misdemeanor.

The board provided that any person entering Georgia while suffering from a venereal disease, whether in a contagious or noncontagious stage, must report to a licensed physician for treatment within 24 hours after arrival in Georgia.

Doctors of Medicine as Others See Them.*—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in *CALIFORNIA AND WESTERN MEDICINE* (July issue, pages 103-109; October, 269-270). Some recent excerpts follow:

* * *

STAY WELL

A recent headline in *Newsweek* said, "Services' Call for Doctors Means United States Must Stay Well." And the statistics back that up thoroughly.

This country has 176,000 physicians, of which 22,000 have been taken by the army. If the goal of a 9,000,000-man army is attained, about 58,000 doctors—one-third of the nation's total—will be in uniform. And the situation is about the same in the case of nurses. We have 300,000 trained nurses—and 50,000 will be required for the army and the navy by the middle of next year.

No one can complain about this—America's fighting men will and must have the best medical attention possible. What it means is that all remaining doctors must work far harder and longer than ever before. The medical schools are stepping up the tempo of medical training as far as practical. And, in addition, civilians must help. Here is how *Newsweek* puts it: "The civilian will also have to pull his oar in the boat. Instead of expecting punctual appointments and home visits, he will have to wait his turn in the doctor's waiting room. Preventive medicine will loom larger. Face-lifting operations will have to yield precedence to emergency appendectomies. By the war's end, hypochondriacs and the bedside manner alike may well have become part of America's past."

This is a small "sacrifice" indeed for the civilian to make in the interest of our soldiers' health—as well as the health of those who stay at home. Give our doctors this kind of sensible coöperation—and America's standards of medical care will remain the highest in the world.—*San Mateo Times and Leader*, October 5.

* * *

HEALTH AND VICTORY

As the army and navy grow, so do their medical corps. The result is inevitable: a shortage of doctors to care for the health of the civilian population. In fact the army already has told the nation that it cannot expect to have more than one doctor for each 1500 civilians, and even that may be an optimistic estimate.

Since the supply of doctors is strictly limited and new ones cannot be trained overnight, the nation faces the considerable task of trying to keep healthy without recourse to its usual amount of medical assistance. If the nation can do so, the shortage of physicians will not have serious repercussions; if it cannot, the war effort is certain to be effected adversely. . . .

It might be well for all of us to brush up on the principles of health and hygiene in an effort to keep

* For editorial comment, see page 287.

the nation as healthy as possible. Although we can't learn enough to have the equivalent of a doctor in every home, we can absorb sufficient essential information to make easier the job of the doctors who are left us and to assure the armed services of the full medical care which they require.—*San Diego Union*, October 12.

* * *

BE THOUGHTFUL OF DOCTORS AND NURSES

Nobody, in these times of stress and scarcity, should waste the valuable time of physicians and surgeons by running to the doctor's office with imaginary ills. All the time of every doctor is needed now in the treatment of persons with serious ailments. Physicians must devote their time to keeping war workers on the job as many days as possible and prescribing for citizens who are actually suffering. Persons who allow their nerves to get the better of them and imagine they are being neglected should frequently take a nice long walk in the sunshine.

These are times when every good American should try to live sensibly and avoid excesses or exposures that may lead to ill health. Special attention should be given to the physical welfare of children. Keep them dry and warm while outdoors. See that they get plenty of wholesome food. In other words, keep them well.

The military service is calling for more and more physicians. Yesterday the dispatches said fifty thousand medical men are wanted for service to their country. In medical attention, as in everything else until this war is won, the men in uniform come first. Every city in America has lost many of its physicians. Those who left must carry on the work by taking care of their own patients and those of absent doctors as well. We should bear this in mind and stop doing things that cause us to require the help of medical men. It is perfectly proper to call a physician if one is really ill. But "enjoying frail health" is one of the luxuries we shall have to forego for the duration, along with joy-riding.

We have a war to win.—*Porterville Recorder*, September 29.

* * *

DOCTORS PRESSED FOR TIME; LOCAL FOLKS CAN HELP

One of the most perplexing problems your doctor has to face today isn't even mentioned in the medical books. It is the lack of time.

Already, many thousands of physicians have left their private practice to service with our armed forces. By the end of the year thousands more will be in uniform.

All this means that the demands on doctors at home will be heavier than they have ever been before. And since your family physician may have to do the work formerly done by two, or even three physicians, he will need all the help and coöperation you can give him during this emergency.

What can you do to help save his time? A number of things. For example, let us suppose that you don't feel well, but are not so ill that you have to go to bed. In that case, telephone your doctor and describe your symptoms. He will tell you whether it is better for you to wait at home until he comes, or go to his office.

If you are not able to be up and around, and you have to call the doctor to your home, try to telephone him at a reasonable hour—say, before he starts out in the morning. If you and all his other patients do this, he can plan his day's visits more efficiently. You'll not only be helping him save time, gas, and tires, but because you called early, he may perhaps get to see you sooner than he otherwise could.

If you should become seriously ill and your doctor

should advise you to go to the hospital, do so by all means. There he can arrange for you to receive the extra care that means so much toward getting you back on the job sooner.

The best way health on the home front can be maintained during the war is for you and your doctor to work together as a team.—*Dinuba Sentinel*, September 17.

* * *

CIVILIAN DOCTORS TO BE SCARCE

The most serious problem faced by the medical profession today lies in the vast numbers of doctors who are being called to service with the armed forces. It is the government's policy that American fighting men must be given the finest medical care possible, and doctors are joining up by the thousands.

In order to meet both military and civilian needs for doctors, medical groups are taking definite action. During the next three years, for instance, U. S. medical school will graduate more than 21,000 students as a result of recently-adopted programs for accelerating the education process. This is 5,000 more than would have been graduated without the accelerated programs.

Retired doctors are coming back into the harness, and other doctors are working harder. The most efficient utilization of all our medical resources is rapidly being attained.

So far as the patient is concerned, authorities are urging that everyone do what he can to "spare the doctor." That simply means that we shouldn't ask for unnecessary house calls, and we shouldn't waste the doctor's time when he comes. If you take more of his attention than you actually need, someone else may have to go without. If patients will remember this, it will help greatly to solve the problem.—*Palmdale Antelope Valley Press*, September 24.

* * *

AMERICAN ACHIEVEMENT

In some circles, the opinion seems to be held that medical groups have consistently opposed any and all efforts to give the people of the country better health protection, and better treatment when ill. The fact is, as any informed man knows, that the doctors are as eager as anyone to put into effect sound and progressive innovations.

The American hospital system is an example. It is, beyond argument, the best system of its kind on earth. It is designed to give people of small means treatment as good as that given people of large means. Like anything created by humans, it probably has its faults. But, by and large, it has been a great success, and has made tremendous contributions to the health of the nation.

Doctors have, and necessarily, opposed radical schemes for socializing medicine—for making doctors governmental employees, dependent on political favoritism for their jobs and their incomes. The records show that, in every nation where socialized medicine exists, the standard of national health is far below ours—and far less progress is made in fighting and controlling disease. In this nation, under our system of private medicine, many of the most revolutionary medical discoveries in history have been made—and progress never ends. At this particular time, the work being done by American doctors in the all-important field of war medicine is particularly outstanding.

The American medical system has worked. It has produced health, happiness, and longer life, for millions. It is one of the typically American achievements.—*Los Angeles Ind. Review*, October 1.

Life is long if it is full.

—Seneca, *Epistulae ad Lucillum*, Epis. xciii, 2.

Kaiser Enlarges Permanente Hospital Building

Ground has been broken for a \$200,000 addition to the Permanente Foundation Hospital, the California Kaiser Co. announced today.

The new development, supplementing the existing Foundation Hospital at MacArthur Blvd. and Broadway, Oakland, was made necessary by the increased number of workers in the three Richmond shipyards.

It was also revealed that work will begin within two weeks on a 20- by 60-foot extension to the field hospital operated by the Foundation at 14th Ave. and Cutting Blvd., Richmond.

Actual construction costs of the new Oakland addition will be \$130,000. The other \$70,000 will be used to equip the 12 four-bed wards and two single bedrooms, and for landscaping and other sundry items. The structure will be a one-story and basement building. All wards and rooms will have outside exposure.

The Richmond undertaking will require about 45 days of construction. Plans are also under way for building a 50-bed in-patient wing at the field hospital, it was stated.

The Foundation was recently established by Mr. and Mrs. Henry J. Kaiser to provide hospital care for workers at the Richmond yards which now number more than 70,000.—San Francisco *News*, November 2.

Kaiser Adds to Permanente Hospital in Oakland

Ground was broken today for construction of an addition to the Permanente Foundation Hospital at MacArthur Blvd. and Broadway, Oakland.

Doubling the hospital's present capacity for "in" patients, the \$100,000 addition will help ease the strain on facilities caused by the increasing number of Richmond shipyard workers, now numbering more than 70,000, according to Ned Dodds, supervising constructor for the California Kaiser Company.

The development will be followed in two weeks by a 50-bed in-patient wing at the field hospital operated by the Foundation at Fourteenth Ave. and Cutting Blvd., Oakland.—San Francisco *Call-Bulletin*, November 2.

OPA Lists 20 Classes for 'C' Gas Ration Cards

A list of twenty classifications in which automobile drivers may be eligible for extra gasoline under rationing was announced on October 27, by the Office of Price Administration (OPA).

At the same time the OPA said that eligibility for "C" or extra ration cards generally will be tightened when national rationing begins November 22. One notable example will be the elimination of all types of salesmen from the preferred class.

How It Works

Announcing the preferred lists, the OPA said:

"No ration for occupational driving will be allowed unless the applicant establishes either that he has formed a ride sharing arrangement with at least three other persons, or that this is not feasible and that no reasonably adequate alternative means of transportation are available."

These are the "C" or preferred mileage classes:

By officials, representatives or employees of a Federal, State, local or foreign government on official business; by officials, representatives or employees of the American Red Cross on official business.

Law Makers

Daily or periodic travel between home and work is not to be considered official business under the plan. . . .

By a physician, surgeon, dentist, osteopath, chiropractor, or midwife, for making necessary professional

calls outside his office if he regularly makes such calls or for travel between offices maintained by him, but only if the applicant is licensed as such by the appropriate governmental authority.

By a farm veterinary for rendering professional services at agricultural establishments, but only if the applicant is licensed by the appropriate governmental authority and regularly renders such professional services.

By a medical intern, student of an accredited medical school or a public health nurse (but not including a private nurse) employed by or serving under the direction of a clinic or hospital, governmental agency, industrial concern, or similar organization, for rendering necessary medical, nursing or inspection calls.

By an embalmer for rendering necessary services in connection with the preparation for interment of deceased persons, but only if the applicant is licensed as such by the appropriate governmental authority. . . .

By a duly authorized religious practitioner, other than a minister, in serving members of an organized religious faith in the locality which he regularly serves. This does not include travel from home to place of worship. . . .

By workers, including executives, technicians and office workers, for necessary travel to, from, within or between military and hospital establishments, public utilities and industrial, extractive or agricultural establishments essential to the war effort, for purposes necessary to their functioning or operation. This does not include travel for sales, promotional and certain other purposes.

For transportation of authorized agents of government, management of labor, to, from, within or between the establishments specified in the preceding paragraph in order to maintain peaceful industrial relations. . . .

By members of the armed forces of the United States or State military forces on official business, where no military vehicle is available or for necessary transportation between home or lodging and post of duty (but not for transfer from post to post). . . .—San Francisco *Examiner*, October 28.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Highest Court Will Review Medical Case

Tribunal Agrees to Decide If Practice is 'Trade' Under Act

Washington, Oct. 12.—The Supreme Court agreed today to review the antitrust law conviction of the American Medical Association and the District of Columbia Medical Society with its question of whether the practice of medicine is a "trade" within the meaning of the Sherman Act.

Plot Convictions

The medical societies were convicted in May, 1941, of conspiracy to restraint trade in the District of Columbia, in violation of the Sherman Act, through activities allegedly aimed at Group Health Association, Inc., a cooperative organization designed to procure low-cost medical treatment for its members, mostly Government employes.

Among other acts, the societies were alleged to have sought to foster a boycott of physicians connected with the cooperative.

The A.M.A. was fined \$2,500 and the local society \$1,500. . . .—San Francisco *Examiner*, October 14.

* * *

Medical Plan Here Outlined

Organized medical and dental service in the Greater Vallejo area on a rationed basis is the chief feature of a plan proposed by the War Manpower Commission in San Francisco which has termed Vallejo as one of the areas in the United States suffering a critical shortage of medical care for civilians, it was revealed today.

The plan calls for cooperation between the U. S. Public Health Service and the WMC to stretch health service over the entire community under a joint financing by federal and state governments.—Vallejo *Chronicle*, September 23.

"Political Notice"

Editorial comment is made in the current issue of CALIFORNIA AND WESTERN MEDICINE concerning a certain "political notice." Part of the text of the notice appears below, for the information of readers. (For editorial comment, see page 283. Quotation follows:

"The above shows the SINISTER PLAN. Now you know WHY Dr. Ray Lyman Wilbur, M.D., wants a MEDICAL MONOPOLY in California. Isn't it perfectly plain that he and his cohorts intend to be THE Medical Dictators of California?

"Through their Medical Schools THEY will DICTATE the courses, control the thought and action of ALL medical students. They will REGIMENT the Nurses. Through their newly created Super State Board of College Professors—from their own colleges—they will say who shall and who SHALL NOT practice the healing-arts in California. The Medical Trust and the Medical Dictators will be in ABSOLUTE CONTROL.

"And Just WHO is Dr. Ray Lyman Wilbur, M.D.?

"Could it be possible that he has a SELFISH MOTIVE?

"A former President of the American Medical Association, for years a prominent member of its Governing Board, and Chairman of its all powerful Council on Medical Education and Hospitals, it is now evident that Dr. Ray Lyman Wilbur, M.D., is DETERMINED to create a Medical Dictatorship in California.

"That is WHY he wants YOU to vote for his PET MONOPOLY. That is WHY he asks YOU to give up YOUR Freedom of Speech, YOUR Freedom of Thought, YOUR Freedom of Action, YOUR Freedom of Religious Practice. He is the man who would be the Hitleresque Medical DICTATOR OF CALIFORNIA, setting up "FIVE LITTLE HITLERS" on a NEW State Board to do his bidding. This Great "I AM" of the Medical Monopoly would even tell YOU whether or not YOU could PRAY for DIVINE GUIDANCE—actually DICTATE which religious groups could use PRAYER to HEAL THE SICK.

"Is THAT your idea of WHAT our hoys are fighting for?

"Is THAT your idea of FREEDOM, DEMOCRACY, LIBERTY, and JUSTICE?

"Let's SMASH this SINISTER plan NOW!

"Would YOU be willing to DIE on foreign soil to enable a man in this country to *snatch your freedom* from you and become a medical DICTATOR?

"Shall we SACRIFICE our SONS and DAUGHTERS on foreign soil for that kind of FREEDOM?

"Fortunately for the U.S.A. very FEW people have the same sort of ideas as Dr. Ray Lyman Wilbur, M.D., and his gang of MEDICAL MONOPOLISTS. That's WHY the people of California are going to DEFEND HIM and his gang by Voting NO on BOTH Propositions No. 3 and No. 16."—San Francisco News, November 2.

* * *

Doctors Get Pay for City Aides' Services

Checks totaling \$23,248.50 were being mailed today to doctors serving the municipal employees' Health Service System, compensating them for July services at the rate of 90 cents on each \$1 unit.

The July payment compared with 88 cents on each \$1 unit for June. Other bills authorized for payment by the system's directors were: hospitals, \$6,582; x-ray laboratories, \$940; clinical laboratories, \$562, and ambulance service, \$78.—San Francisco Call-Bulletin, September 30.

* * *

Medical Society to Revise Index

To make the services of qualified physicians easily available to San Francisco's many newcomers, the San Francisco County Medical Society announced today it is revising and bringing up to date its official index of general practitioners and specialists.

Revision of the list to reflect its currently active membership is particularly necessary at this time because one-fourth to one-third of the city's doctors are serving in the armed forces.

Persons who need the services of a physician may telephone the Medical Society, 2180 Washington St., at Walnut 6100. Inquirers are furnished a list of available doctors whose names are chosen in rotation from a permanent file.—San Francisco News, October 5.

* * *

Permanente Health Plan in Effect at Richmond

Richmond.—With the dedication last month of the Permanente Foundation Hospital in Oakland, made possible on a nonprofit basis to Richmond shipyard workers by Mr. and Mrs. Henry J. Kaiser and the Maritime

Commission, the Permanente Health Plan is being set up for each of the employees of the Richmond yards.

Already set up in Yards One and Three since August, the plan is now being put into operation at Yard Two.

Time checkers will be thoroughly instructed as to the details of the Permanente Health Plan, which is to operate for individual employees on a payroll deduction basis for those who sign up, and booklets which give the details of how to secure its benefits are now being circulated.

It is hoped that the Health Plan will greatly reduce manpower loss through illness which by means of immediate and adequate attention may be prevented.

Representatives of the Permanente Foundation will be available, it is reported, to explain in detail the employee benefits which can be derived from participation in the Health Plan.—San Francisco Bay Area Shipbuilder, September 13.

* * *

Need for Planned Parenthood Urged at Mother Clinic Meet

"There is nothing more important just now than to see that every child coming into the world is born under circumstances that assure it health and proper environment. The problems facing us are severe, but if we can assure that the new babies are received into a world that will make them fine citizens, we are working toward the solution of many of our ills and establishing a worthwhile youth for tomorrow. There is no question but that dissemination of the knowledge of planned parenthood is one of the most tremendous contributions we can make to our times."

Speaking yesterday before a large number of San Diego's leading women at a luncheon meeting in the San Diego Women's Club of the San Diego Mothers' Clinic Association, its honored guest, Mrs. Hancock Banning, Jr., made that statement. Mrs. Banning, who came from Pasadena, is the chairman of the southern section of the California League of Planned Parenthood, of which the Mother's Clinic group is a part.

State Has Great Need

Citing the question often raised, "why stop having babies now when we need to replenish our youth?" Mrs. Banning called attention to the goal of the league, which is not to prevent the arrival of children, but to teach parents, so many of whom are involved in physical and economic problems in this war production period, how to space their arrival and assure the mother's best health and mental ease, which is reflected in the child's well being.

California, with its migrant population problem, has a tremendous need for this service, she pointed out, and "has a program to be proud of." San Diego's Mothers' Clinic is one of the few now operating in the State and is doing a splendid service, she said, under the leadership of Mrs. Irving E. Outcalt, president.

'Have Foot in Door'

Emphasis is not put on birth control, but on the idea of having babies when health and family finances of the family are ready for them, she stressed.

Speaking on organizational problems and plans, she reminded that the California League for Planned Parenthood is three years old and is now recognized as an integral part of the State's social work. "We have our foot in the door," she said, but urged concentrated work to gain universal understanding, the approval of the California State Medical Association and to have planned parenthood included as a public health measure with other maternity and child health services. The American Medical Association already has recognized the work of the league, she stated, but the California group has not as yet done so. . . .

Value of the work has been amply demonstrated, she said, by results obtained in a several months' service by a registered nurse in migrant camps in the northern valleys. The State league, she said, is hoping to put this nurse on permanently. "The only obstacle to our work is a lack of understanding as to what 'planned parenthood' means," Mrs. Banning reiterated. "Work of this nurse established such understanding and removed the fears and feeling of physical danger or harmful practices so prevalent with those who do not know its meaning." That California has the backing of the Parent-Teacher Association is a great point in assuring its final victory, Mrs. Banning commented. . . .—San Diego Union, September 25.

* * *

Court Holds Drug Makers Responsible for Dire Effects
San Francisco, Aug. 20.—(AP.)—A State Supreme Court

opinion held today that under certain circumstances the manufacturer should share responsibility with the prescribing physician if a drug has damaging effect upon a patient.

The opinion was delivered in quashing demurrers to a damage suit brought by Mrs. Cecilia Wennerholm against the Stanford University School of Medicine, the Stanford University Hospital, the Stanford Board of Trustees and the Cutter Laboratories of Berkeley, Calif.

Mrs. Wennerholm asked \$75,000, maintaining that a drug (dinetrophenol) she took during 1934 and 1935 to lose weight caused her to become completely blind. Her attorney told the court she had used the drug on advice of her physician because of representations the defendants had made for it in medical journals.

The Supreme Court, reversing the San Francisco Superior Court and the district court of appeals, both of which had sustained the defendant's demurrers, held that Mrs. Wennerholm had grounds for action. The court stated:

No cases have been cited to us which support the proposition advanced by defendants that in circumstances such as those alleged here, a prescribing physician must accept sole responsibility for the treatment which he chooses for his patient.

It seems to us a more reasonable view that one who manufactures and sells a drug dangerous to life and health, knowing it is dangerous, should be liable where . . . both physician and patient rely upon the representation made for the drug.—*Sacramento Bee*.

Luxury Nursing Out for Duration, Says Nurses at Wartime Parley

The invalid who expects a trained nurse to greet visitors, arrange flowers, and answer her telephone—is out of luck for the duration. Trained nurses are pledged to war service, and "luxury nursing" is out. Speakers put the emphasis on nursing essentials as the California State Nurses Association opened its first wartime convention today in Fresno. Miss Shirley Titus of San Francisco, director at headquarters, told what nurses are doing to meet this crisis, and Dr. Anthony J. J. Rourke, superintendent of Stanford University Hospital, warned about cutting out the "frills." Addressing the private duty section meeting, Dr. Rourke said:

"The nursing profession, through its war service program, has already achieved a great deal toward putting itself on war footing, but much still remains to be done. We should make sure that no nursing is used where it is not needed, but the public recognizes the necessity of foregoing luxury nursing.

"Registered nurses should be used only for professional duties, and should leave the other services to nurses' aides. Only by adherence to this principle, and with understanding from our patients, can we expect to overcome the increasing nurse shortage and properly protect the public health. To give the utmost of our nursing resources to the war effort, must be the mutual goal of the nursing profession and the hospital administration.

"I do not mean that standards should be lowered. There is no substitute for registered nurses. By the profession's own expanding efforts and the coöperation of all who have to do with the problems, machinery set up by the California State Nurses' Association can function effectively for victory." . . . —*San Francisco News*, October 3.

MEDICAL EPONYM

Von Pirquet Reaction

Clemens F. von Pirquet (1874-1929), described "Tuberkulindiagnose durch cutane Impfung [Tuberculin Diagnosis by Means of Cutaneous Inoculation]" before the Berlin Medical Society on May 8, 1907, and his remarks were reported in *Berliner klinische Wochenschrift* (44:644, 1907). A portion of the translation follows:

"If a tuberculous child is inoculated with tuberculin, there appears at the site of the inoculation a small papule that is bright red at first, gradually becomes dark red, and fades out within a week. . . . Nearly all cases of clinical tuberculosis in children give a positive reaction. . . . With increasing age, the reaction becomes more and more frequent, so that among adults nearly all patients show this reaction."—R. W. B., in *New England Journal of Medicine*.

Basic Science Initiative: Vote by California Counties, with Precints

For Editorial Comment, see Page 283

Total Prcts.	County	Prcts. Rptg.	YES	NO
1,428	Alameda	1,388	65,969	81,362
5	Alpine	5	14	53
25	Amador	25	410	1,135
133	Butte			
34	Calaveras	34	514	1,199
28	Colusa	7	53	76
237	Contra Costa	223	1,042	16,802
23	Del Norte			
45	El Dorado			
258	Fresno	238	5,949	16,301
35	Glenn	16	398	870
120	Humboldt	75	2,128	2,964
85	Imperial			
35	Inyo	27	458	956
307	Kern	163	3,769	8,930
66	Kings	63	1,413	4,597
32	Lake	32	488	1,405
49	Lassen			
5,312	Los Angeles	2,996	117,618	206,196
43	Madera			
129	Marin	129	6,139	6,078
22	Mariposa			
89	Mendocino			
78	Merced			
25	Modoc	8	105	288
8	Mono	1	11	63
128	Monterey	77	3,204	4,788
58	Napa	34	1,858	2,070
43	Nevada	6	23	83
263	Orange	263	9,579	26,940
66	Placer	15	271	889
31	Plumas			
179	Riverside	178	6,551	16,224
327	Sacramento	318	8,797	22,700
29	San Benito	29	1,149	1,092
386	San Bernardino	195	4,380	13,175
735	San Diego	321	9,134	17,151
1,187	San Francisco	1,187	87,741	71,676
244	San Joaquin	244	5,816	19,592
90	San Luis Obispo	42	1,569	2,805
281	San Mateo	168	14,764	14,876
132	Santa Barbara			
373	Santa Clara			
110	Santa Cruz	69	2,432	4,742
67	Shasta			
16	Sierra	3	37	104
76	Siskiyou	66	1,173	2,649
108	Solano			
181	Sonoma	137	4,362	7,898
132	Stanislaus	134	4,188	11,309
39	Sutter			
55	Tehama	54	1,034	2,022
24	Trinity	24	214	495
154	Tulare	135	4,192	10,598
48	Tuolumne	41	683	1,425
135	Ventura	134	3,610	9,006
52	Yolo	52	2,205	3,324
38	Yuba			
14,438	Totals	9,356	385,444	616,908

—San Francisco Examiner, November 5.

We live in deeds, not years; in thoughts, not breaths;
In feelings, not in figures on a dial.
We should count time by heart-throbs. He most lives
Who thinks most, feels the noblest, acts the best.

—P. J. Bailey, *Festusi: A Country Town*.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

San Francisco

Cash Sickness Compensation; A New Type of State Legislation

Most states in the Union now have some form of an unemployment compensation act whereunder certain specified amounts will be deducted from the wages or salaries paid to employees subject to the act and, in the event of unemployment, they are entitled to benefits for a limited number of weeks in amounts proportionate to the contributions they have made to a central fund.

The State of Rhode Island at the last session of the Rhode Island General Assembly adopted an act supplementing its already existing unemployment compensation act. The new act, to be known as "Rhode Island Cash Sickness Compensation Act," is a law relating to cash sickness insurance. It is the first legislation of its kind to be enacted by any state legislature in the country, and should be of interest to the medical profession as a whole.

The declared purpose of the act is "to lighten the burden which now falls on the unemployed worker and his family" by providing for weekly benefits to be paid to workers who are unemployed due to sickness.

The legislation, effective May 10, 1942, establishes what is known as the "Rhode Island Cash Sickness Compensation Act" which is to be administered and benefits paid thereunder by the already existing Rhode Island Unemployment Compensation Board without liability on the part of the state beyond the amounts paid into and earned by the fund. The Treasurer of the State of Rhode Island is the custodian of this fund, which consists of all contributions made pursuant to the provisions of the act. Each employee, defined as meaning any person who is or has been employed by an employer within the meaning of the Unemployment Compensation Act, is required to contribute to the fund an amount equal to one per cent of his wages paid by his employer up to \$3,000.00 in any calendar year. The employer is responsible for withholding such contributions from the wages of his employees at the time such wages are earned or paid, and must transmit all such contributions to the fund in the custody of the State Treasurer.

The fund so created, together with its earnings, is then used to pay weekly benefits to workers unemployed due to sickness, and it is provided in the act that an individual shall be deemed to be sick in any week, in which, because of his physical or mental condition, he

is unable to perform any services for wages. The amount of weekly benefits range from a minimum of \$6.75 per week to a maximum of \$18.00 per week, depending upon the amount which the employee has previously earned and the contributions which he has made to the fund. The gross amount of benefits payable, and the duration thereof, are also limited on the same basis.

The Unemployment Compensation Act would seem to overlap this new type of legislation in that an individual might conceivably be eligible for payments under both the unemployment act and the cash sickness act. To avoid any possibility of double payment of benefits, Section 6, entitled "Benefit Eligibility Condition," provides that an individual shall be disqualified from receiving benefits in any week with respect to which he will receive remuneration in the form of compensation under workmen's compensation law or primary insurance benefits under the Federal Social Security Act or benefits under the Unemployment Compensation Law of any state or the United States. If, however, the amounts to be received under any of these acts is less than the amounts payable from the cash sickness compensation fund, then the worker is entitled to receive the excess.

The administrative provisions of the act provide for appeal tribunals wherein a referee is appointed by the unemployment compensation board to hear disputes over decisions of the original claims examiners employed by the board. A further appeal to the Unemployment Compensation Board is provided and an individual obtaining an adverse decision before the board may petition the Superior Court of the county in which he is employed for a review of the board's action.

LETTERS †

Concerning Medical Literature for Colleagues in Military Service

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

Committee on Postgraduate Activities

October 1, 1942.

Subject: *Medical Literature for Colleagues in Military Service: A Request for Coöperation.*

Addressed:

The Component County Medical Societies of the C.M.A. and the Medical Staffs of California Hospitals.

Dear Doctors:

CALIFORNIA AND WESTERN MEDICINE, in its September issue (on pages 169 and 170), outlined a plan through which an attempt will be made to supply the many physicians who are now attached to hospital stations of Army, Navy and Air Forces camps located in California with some of the current medical literature. (Note. See also

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

October issue, on pages 227 and 250.)

As stated in the editorial comment, it is hoped that members of the component county medical societies and of hospital staffs throughout the State of California, will give full coöperation in this effort to send medical journals to military colleagues who are now stationed in our State.

The Postgraduate Committee of the California Medical Association has taken over this work and will be glad to render all possible aid in collecting and forwarding medical publications that may be left with county medical society officers, or with hospital staff executives.

If it is not convenient for you to place with, or forward to the University of California, Stanford or Los Angeles County Medical Libraries journals that have been collected, the same may be forwarded *collect*, via "Railway Express Agency," addressed to the C.M.A. Postgraduate Committee, Room 2004, 450 Sutter, San Francisco. The undersigned will then be happy to carry on from that point, as regards distribution to suitable military hospital stations.

In order to bring this matter to the attention of as many of your members as possible, request is also made that you read this communication at a county medical or staff meeting, and if you issue a bulletin, print an item concerning the same therein.

Perusal of the editorial comment on this subject in the September issue of CALIFORNIA AND WESTERN MEDICINE will acquaint you with details of the plan. This letter is written to bring home to you the importance and urgency of *early coöperation*.

The hope is also expressed that an attempt will be made by your respective officers or a special volunteer or other committee appointed for the task, to carry on this work from month to month, so that the supply of medical literature may regularly go forward.

The undersigned is at your further service in the work.

Thanking you for your coöperation,

THE CALIFORNIA MEDICAL ASSOCIATION
through its

COMMITTEE ON POSTGRADUATE ACTIVITIES.

By GEORGE H. KRESS, M. D., *Secretary*.

The addresses of the three libraries follow:

U. C. Medical Library, the Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California. (Stanford.)

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," *collect*, to:

C.M.A. Postgraduate Committee,
Room 2004, 450 Sutter Street,
San Francisco, California.

Concerning Plan to Supply Medical Journals to Colleagues in Military Service*

(COPY)

HONOLULU COUNTY MEDICAL SOCIETY

Honolulu, Hawaii, U.S.A., October 20, 1942.

To the Editor.—I have seen the editorial in the September issue of CALIFORNIA AND WESTERN MEDICINE, outlining a plan for collecting medical journals for distribution to the physicians in the services. It sounds like a splendid idea and I hope you will get a ready response. I am acquainted with many of the medical officers sta-

tioned in various parts of the island and know how isolated they feel and how heavy time hangs on their hands.

It occurred to me that the Library of the Honolulu County Medical Society might be helpful in distributing in the Hawaiian Islands, some of the journals so collected, particularly on the Island of Oahu where Honolulu is located.

Since the outbreak of the war we have thrown our library open to all the service doctors, giving them the same lending privileges as county society members and we have been gratified in the way they have used it. While the Army has a fine medical library at one of its hospitals, the men from the outlying posts seem to prefer to come to us, perhaps because our library is centrally located in Honolulu and because we have a very restful, not to say luxurious, reading room. The Navy has no library to speak of, and the men from the Naval Hospital come in to do their reference work and reading here. In fact, I might say that the library is more useful to the military doctors than to our own county society members who are so very busy these days.

All this is a preamble to show that we are in touch with the men in the outlying posts as well as at the larger concentrations and that we know what their needs are. The current journal files of our library are in the main complete and we subscribe to about 50 of the leading journals. We cannot, however, allow the very recent journals out on loan, for obvious reasons. It would be helpful, therefore, if we could build up a journal file for the military doctors at some of the larger concentrations.

Depending upon the journals that are turned in, I believe two or three sets of the more popular journals could be placed at strategic locations. If you have material available to go beyond this, I believe each of the islands of Hawaii, Kauai, Maui and Molokai could profit by some material, as I do not believe any of the county societies on these islands have adequate libraries. If you wish to go still further, journals could be rotated to Johnson Island and the other line islands where only one or two doctors are stationed, but are terribly isolated.

In all of this I would be most eager to be of assistance as an individual as well as librarian for the Honolulu County Medical Society.

Very sincerely,

(Signed) ELIZABETH D. BOLLES, *Librarian*.

Concerning Medical Literature for Military Colleagues

(COPY)

STATION HOSPITAL

LUKE FIELD, PHOENIX, ARIZONA

Office of the Chief of the Medical Service

October 12, 1942.

To the Editor.—The desert is filled with planes and sunsets, cadets and coccidioides, but it is short on books. Herbert Mooney and I are thoroughly enjoying our part in helping to "Keep 'em flying" but we miss the Los Angeles County Medical Library.

We have started a library at Luke and I am asking for contributions. We would like files of all the standard journals starting in 1935. I am sure that many members have old journals they do not plan to keep permanently. Perhaps there are texts that are not too old. The other day I needed an anatomy. Someone might be able to part with his old numbers of the Quarterly Cumulative Index. Someone might want to forward current numbers of a journal we do not get after he has read it.

If any of these can be sent to the Los Angeles County Medical Library, I will arrange for transportation to Arizona. One might check by phone with the librarian

* CALIFORNIA AND WESTERN MEDICINE, October, 1942, on pages 227 and 250 gives detailed information concerning the plan proposed by the Postgraduate Committee on the California Medical Association.

first to avoid duplication but in such case I suspect that some of the other nearby Army Hospitals would like to have them.

We will be pleased to have books or journals on loan for duration. These will be carefully protected and returned after the emergency.

My best regards and thanks.

Sincerely yours,

LEWIS T. BULLOCK, *Captain A.A.F.M.C.*

Concerning Leases of Physicians Entering Military Service*

(COPY)

San Francisco, October 28, 1942.

F. Burton Jones, M.D.,
Secretary, Solano County Medical Society,
Vallejo, California.

Dear Doctor:

I have delayed answering your letter of September 29, 1942, until such time as I could give you a definite answer with regard to the existence of any legislation which would permit physicians to "void a lease or render it inactive for a period of time" while in military service. At the time your letter was received, the Soldiers and Sailors Civil Relief Act of 1940 contained no provisions which offered any substantial help to a physician who desired to be relieved from the obligations of a long-term lease because of his inability to maintain the lease by reason of his entry into the military service. Amendments to the Act were pending at that time.

These amendments were recently signed by the President and Section 304 is thereby added to said act. This section provides that any lease covering premises occupied for dwelling, professional, business, agricultural or similar purposes, where such lease was executed by or on behalf of a person who, after the execution of such lease, entered military service, may be terminated by a notice, in writing, delivered to the lessor at any time following the date of the beginning of the lessee's period of military service.

In the event that the lease provides for a monthly rental, the termination shall be effective thirty days after the first date on which the next rental payment is due and payable subsequent to the date when such notice is delivered or mailed. For example, if a physician has a lease providing for a monthly rental payable on the first day of each month, he may deliver a notice, in writing, to the lessor on the last day of any month and the notice will be effective to terminate the lease on the last day of the next succeeding month thereafter (a notice of termination delivered to the lessor on or before November 30th would be effective to terminate a lease, providing for monthly payments of rent, on December 31st). In the case of all other leases, termination shall be effective on the last day of the month following the month in which such notice of termination is delivered or mailed.

By the terms of the act, delivery of such notice of termination may be accomplished by placing said notice in an envelope properly stamped and duly addressed to the lessor or to the lessor's agent and depositing the notice in the United States mail.

In the case of the termination of a lease under this section, any unpaid rental for a period preceding the effective date for the termination of the lease is proratably computed and any rental paid in advance for a period succeeding such termination date must be refunded by the lessor to the lessee.

This section will afford relief to all physicians and sur-

geons and now occupying offices under long-term leases in that they can relieve themselves from the obligation to pay rental under the lease after they have entered military service.

No doubt a number of physicians will desire to maintain their offices while in military service so that they may return at the end of the war and resume their former practice. Of course, there is no way in which this can be accomplished unless any existing lease is renewed and its terms and conditions fully complied with. In order to accomplish this, it would seem necessary to find some physician or surgeon to care for the practice of the doctor entering military service until such time as he may return. In this connection, I refer you to a Medical Jurisprudence article which will be published in the October issue of CALIFORNIA AND WESTERN MEDICINE, relating to the legal situation existing between physicians entering military service and those persons who agree to take a position of locum tenens and care for the practice of the physician absenting himself.

There are a number of other benefits extended by the Soldiers and Sailors Civil Relief Act to all persons entering military service with respect to rent, installment contracts, mortgages, insurance and taxes. The purpose of the act is to afford relief to persons whose ability to fulfill their financial obligations is definitely prejudiced by entry into the armed forces and the possibilities offered by this act should be considered by all physicians and surgeons entering military service. The general provisions of the Soldiers and Sailors Civil Relief Act are discussed in a Medical Jurisprudence article contained in the May, 1942, issue of CALIFORNIA AND WESTERN MEDICINE, and I suggest that you read this article. The scope of the act has been extended by recent amendments as indicated by the section in regard to leases discussed above, but the general tenor of the provisions of the act as set forth in this article remain substantially unchanged.

I hope that the information contained in this letter will be of some help to you. If there are any further questions which you wish clarified, please let me know.

Very truly yours,

(Signed) HARTLEY F. PEART.

Concerning a Recent Malpractice Case: Some Observations

Los Angeles, California.

To the Editor:—It can happen to any of us. Out of a blue sky, and apparently without rhyme or reason, a friend of mine was sued for one hundred thousand dollars, plus.

The case in brief: A young woman, pregnant, seen by the physician regularly as an obstetrical case in his office, when about four and one-half months along, developed abdominal pain, cramps, nausea and vomiting; sent home from office with Rx for sedation; seen at residence following day; next morning sent to hospital at 6:05 a.m.

History of indiscreet eating; working diagnosis of toxæmia of pregnancy; enteritis; partial intestinal obstruction (?); the latter based upon suspected adhesions from previous surgery performed elsewhere five years earlier. Patient in hospital two and one-fourth days; marked improvement under sedation and enemas on second day, with five to seven B.M.'s before release; consultation on second day. Sent home markedly improved on third day with definite instructions. A day and night later had relapse. Another doctor was called, a young man just out of school eleven months; snap diagnosis of complete obstruction, patient stated to be in virtual collapse; rushed her to another hospital with no attempt to get in touch with first doctor; then finds they have

* For other comment in CALIFORNIA AND WESTERN MEDICINE, concerning alien physicians, see in October issue, on page 278, and in current number, on page 287.

no money; sends her to third hospital (charity). Following day operation for partial obstruction, stated to be complete only at time of operation as had two good B.M.'s in their hospital, but condition was poor; miscarriage following day; peritonitis; but excellent recovery and left hospital six weeks later. Suit filed three months later against first doctor based upon black picture given relatives by second doctor. Fifteen days in court, jury trial. Cost Lloyd's Insurance about two thousand dollars for defense. Final verdict by jury: unanimous acquittal of defendant.

First: From my observation of this case I learned a good deal. It is no fun to be sued.

Second: The records in this case both at office and in hospital were good. (Far better than the average, according to the attorneys.) They could have been much better. The daily progress notes could and should be better. The orders left should note the hour as well as the date ordered. Nurses' notes should be more carefully signed by them, and consultations should be more carefully recorded and should be complete.

Third: There is a great difference in attorneys. The comparison in the court was noteworthy. The defendant had reason to be very much pleased with excellence of the address, and meticulous care given to the preparation and presentation of the case by Mr. Richard Kirtland, the defense attorney. Credit should be given where justly earned.

Fourth: We have a splendid committee on Medical Defense. Dr. Louis Regan was present in person throughout this physician's ordeal, and his comfort and encouragement were greatly appreciated by the defendant. His work with the various experts was excellent and manifested a complete grasp of medical-legal factors involved. I believe his work in harmonizing the various schools of healing is to be particularly commended and in this objective he justly merits the active aid and support of all good doctors. Let us stop criticizing the other fellow.

Fifth: We all have friends as well as enemies. True medical friends, who will step out of their busy practices as witnesses for the defense, will never be forgotten by the defendant. Four excellent doctors made a preponderous weight of evidence for his case.

In conclusion: Any of us can be sued. It behooves us to keep our records, private and hospital, in the best of shape for that time of need, and ourselves in good standing in the Association. One is happy to be a member of the County Medical at such a time.

E. W. WELLS, M. D.

Concerning Annual Costs of Institutions for the Feeble-Minded

To the Editor.—Sir James Jeans, the British scientist, states: "We of today are building the England of tomorrow, and I fear it will consist far too largely of hospitals, prisons and lunatic asylums. Its population will be too many unemployed, and too many unemployables. This is the price our children will have to pay for our irresponsible humanitarianism and sentimentalism."

England is not alone in this condition. We in America are building hospitals, penitentiaries, insane asylums and homes for the feeble-minded, and spending billions of dollars annually to care for the ever-increasing number of social inadequates, piling up financial and social burdens which will rest far heavier on our children than on ourselves. This is the result of that unintelligent sentimental humanitarianism that has gripped our religious and social leaders and which is increasing instead of diminishing the sum total of misery and suffering.

Any charity that tends only to relieve the misery of

one individual but allows two others to be born into the world to share the same fate is an unintelligent charity. As true medicine is the prevention rather than the treatment of disease, so is true charity the prevention of the need of charity. The basic cause of poverty is biologic—heredity. An intelligent eugenics program will correct this heredity.

EUGENE H. PITTS, M. D.

The Need of Workers, Not Joiners.—There are in all societies—and county medical societies no exceptions—a number of members who may be termed "joiners." Their names appear on the membership list and on special committees, but they take no part in the society's work.

They, all too often, believe that their obligations cease with the annual payment of the county dues. Yet, they are perfectly willing to accept the benefits. These men are not good county society material; the mechanics of progress would become static and finally retrogress if there were not also sincere active members.

First, among the qualities that make a good member, I would place a sincere willingness to do the job. It is not a help to the county for a man to accept a position and then not actively participate in the work of that particular job. Not only is it not a help, but it may be a definite hindrance.

If a man, for example, is willing to accept the honor of representing his county as a delegate, he should attend conventions and take an active part in their discussions. Acceptance with no participation not only is no aid to the county nor to the member, but it prevents some other sincere worker from the opportunity of serving his medical society.

Interest and the opportunity to learn would soon diminish if only a small minority of members regularly attend the regular meetings.

In any large group the work must, of necessity, be done by committees. The setting up of committees and the holding of meetings, no matter how elaborately, accomplish nothing *per se* if the committee heads are not willing to do a little actual work. A man is likely to pay his dues when approached personally; it is only natural to ignore unpleasant "dunning" letters. The better the program a committee member arranges the greater the chance of a large attendance. Too often, in the past, the greatest attendance has been for elections and pure politics.

Postgraduate training demands the whole-hearted support of those in charge. This is one way by which the county performs one of its greatest services—helping the younger man. This, incidentally, works both ways, the younger man is instructed and the reputations of those in charge are enhanced along with that of the society itself.

What I have written above is very fundamental and may seem obvious. But it is upon the obvious and common-place that progress rests. In finis, the success of any project and the dividends which it pays depend upon the amount of work put into that project. Trite, perhaps, but true.—E. A. G., in *Bulletin of the Medical Society of the County of Kings*, Vol. 21, No. 1.

"It is one of the surprising facts of history that time and again peoples have reached a level of material prosperity and have attained standards of culture which would seem to have enabled them to go on into a civilization finer and richer than anything which the world has even known, only to be so overcome by the self-indulgence and the softening process attendant upon these conditions as to fall subject to barbarians who fell upon them."—Dr. Ernest Martin Hopkins.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 11, November, 1917

EXCERPTS FROM EDITORIAL NOTES

Typical "Negligence" Cases and Some Reasons for the Formation of the California Indemnity Defense Fund.—We have on several occasions stated in these columns that many of our members are under the mistaken impression that claims for malpractice and actions for alleged negligence and carelessness are, as a rule, asserted and filed only against the younger members of the profession—those who might be regarded as less skilled or experienced, or against whom some imputation of recklessness might be made. Nothing could be further from the truth. We have also stated on a number of occasions in these columns, and we do not hesitate to say again, that ignorance or rapacity do not discriminate in the selection of their victims, and that the oldest, best qualified, and most experienced of our number are just as much the subject of attacks for alleged malpractice as any others. . . .

The Absent Doctor's Practice.—At the suggestion and request of Dr. J. Henry Barbat, President of the State Society, attention is called to a situation in the medical fraternity which should receive the earnest attention of every medical man in the State. An agreement has been entered by the majority of the profession to protect, to a certain extent, the incomes of their confreres who have gone to the front, first, by giving to the doctor's family, or the doctor himself, one-third of the fees collected from his patients, and, second, by returning the patient when the doctor returns from the war. . . .

It is suggested that the county societies again take up this matter with their members, and instruct them to keep a separate account of all patients of men who have gone to the military service, so that when the latter return, they may receive a full account of the work done for them by their friends at home. . . .

Status of Health Insurance.—The war has so changed conditions as to render it practically impossible for us to look to England for the information which we so much needed before being able to draw a definite conclusion as to the good or bad results from health insurance. Conditions in other European countries where health insurance is enforced are so different from those in the United States as to render deductions from their statistics unsatisfactory. We do know that the system is not working one hundred per cent perfect in England, and that very little change can take place in it until those most concerned have more time to give to its study there.

Editorial Comment.—Little observation is required to show the enormous appetite of the American people for patent medicines. When in doubt, take a drug, seems a common maxim. If you do not see a sufficiently advertised or gaudily wrapped package, ask the druggist and seldom will he fail to provide an attractive carton containing the very thing which is best for your ailment. Too often the physician must bear the onus of invariably prescribing drugs, solely because the patient demands drugs and will not be cured without them. Too often the

(Continued in Back Advertising Section, Page 24)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"Physicians engaged in industrial work, either full or part time, will be retained in their present positions, according to an order issued yesterday by Paul V. McNutt of the War Manpower Commission. . . ." (Los Angeles Times, Sept. 10, 1942.)

"The Police Commission yesterday denied an application for a masseur's permit by Dr. F. M. Seebree, who stated he is a spiritual healer, but not a physician. The applicant said his healing consists of placing his hands on men, women and children; but the board pointed out that a masseur is not permitted under the law to treat the opposite sex." (Los Angeles Times, Sept. 16, 1942.)

"Deputy District Attorney Richard Lawrence announced today that two persons have been arrested and another person is being sought in connection with an illegal operation ring centering its activities here. The ring has preyed upon women throughout Northern California for more than a year, Lawrence said, and was uncovered when a woman was brought to the City Emergency Hospital suffering from the effects of an illegal operation. . . . Burl E. Whelan, former Sacramento chiropractor, was arrested in Vallejo by Sacramento officers on the same charge. Three women now in the Sacramento Hospital have definitely identified Bernard C. King as the man who performed the operations, Lawrence said. Detectives A. J. Soules said King has been averaging from one to three illegal operations per day, and women have been charged from \$50 to \$100 per case." (A. P. Dispatch, dated Sacramento, Sept. 21, printed in San Francisco Chronicle, Sept. 22, 1942.)

"Frederick H. Bott, asserted healing practitioner, was arrested yesterday by Joseph W. Williams, Special Agent of the State Board of Medical Examiners, on a charge of practicing a form of healing without a license. Williams said Bott used the title 'doctor' before his name and professed to treat ailing persons by naturopathy, physiotherapy and other methods. He said he found three alleged diplomas on the walls of Bott's office, two of which Bott admitted he obtained for cash considerations of \$100 and \$75, respectively, without attending the institutions which issued them. Williams said the other was obtained after only three weeks' study. . . ." (Fresno Bee, Sept. 13, 1942.)

"Dr. Arthur M. Tweedie must serve six months in jail as the result of the death of a woman patient. Mrs. Leona Tarleton of Santa Monica, in his office at 3326 West 54th Street last June 1. Superior Judge William R. McKay imposed the jail term yesterday as a condition of the probation which he granted to Dr. Tweedie, after the latter had pleaded guilty to the unusual charge of 'assault by ether.' Originally, Dr. Tweedie had been

(Continued in Back Advertising Section, Page 32)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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FUTURE YEARS will yield many such anniversaries of scientific progress for the benefit of mankind. We pledge ourselves to the future development of chemotherapy and we shall judge our success by the recognition given to the services we render for the masses of common men.



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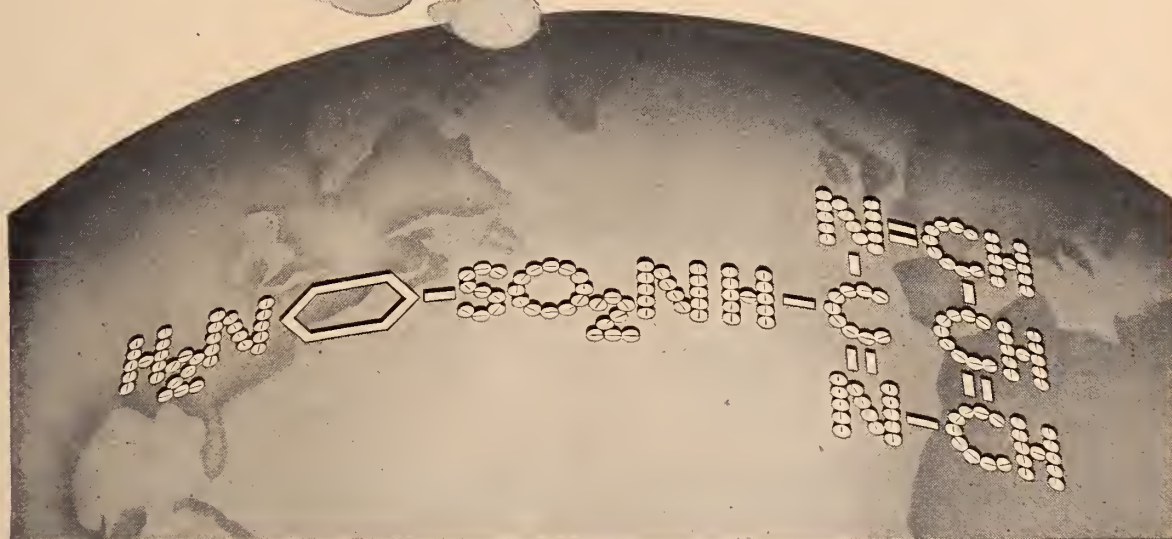
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BOOK REVIEWS

(Continued from Front Advertising Section, Page 18)

Orthopaedic Surgeon to St. Vincent's Hospital, South Highlands Hospital, Hillman Hospital, Children's Hospital, Baptist Hospitals and Jefferson Hospital, Birmingham, Ala. Third Edition. Cloth. Price: \$12.50. Pp. 1303, with illustrations. St. Louis: The C. V. Mosby Company, 1942.

The new third edition of this book on traumatic injuries has the same completeness of the previous editions. It is divided into two parts. Part I, Principles and General Aspects, is worth reading. The authors point out the fact that, in the majority of our general hospitals, there is a lack of necessary apparatus to handle fracture cases. The chapter on First Aid in Fractures and Automobile Injuries is good. The addition on wounds and fractures common to soldiers is a valuable aid to medical officers in active duties. The treatment of compound fractures was rewritten and there is discussion of sulfonamide drugs. The use of these drugs to prevent wound infection in apparently clean cases, and in old, infected fractures is mentioned. More discussion should have been given to the use of plasma, serum and whole blood.

Part II, Diagnosis and Treatment of Specific Injuries, has several revisions in the treatment of injuries to the spine, humerus, and foot. The text is abundantly illustrated. There is adequate and good description of the common injuries. Particularly noteworthy are the emphasis on back strains and an excellent chapter on the wrist and hand. The authors advocate the hanging cast method in the treatment of

(Continued on Page 24)

To help relieve neuritic symptoms of pregnancy

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is proving of increasing value as a routine part of the patient's diet in treating such symptoms as nausea, vomiting, dyspnea, pains in legs and arms, muscle weakness and fatigue.

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BOOK REVIEWS

(Continued from Page 22)

many humeral shaft fractures. Several methods of hip-nailing are given.

The book is a particularly timely revision, since a large number of men in active duties with the armed forces, and many general practitioners, interns and surgeons are called upon to treat the increasing number of industrial injuries. This is the best contemporary work on the subject and a safe reference.

San Diego.

R. O. PECK.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 340)

advertising matter around the package has a greater curative influence than the contents. . . .

It is a source of pride for every physician in the State to read the following in the September *Bulletin* of the State Board of Health: "California is the first State to face the venereal disease problem squarely, and to establish a bureau to handle it directly and vigorously." The tentative program was published in the last issue of the *JOURNAL*. No other single disease factor has been more important in the English and French armies than venereal disease. This alone makes it imperative that the American army be saved from such disaster. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Vegetative Nervous System in Relation to General Medicine," by Francis M. Pottinger, A.M., M.D., LL.D., *Monrovia*.—We are just be-

(Continued on Page 26)

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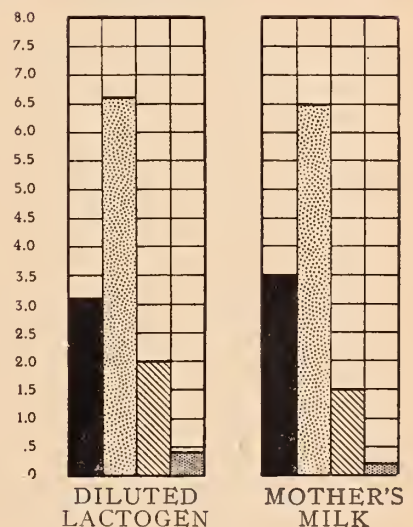
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Clinical Pediatrics, p. 156



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APPROVED BY AMERICAN COLLEGE OF SURGEONS

TWENTY-FIVE YEARS AGO

(Continued from Page 24)

ginning to realize, after many years of study in pathological anatomy, which has heretofore been considered the basis as well as the superstructure of modern medicine, that it fails to explain those conditions which are of most interest to the clinician. Pathological anatomy may acquaint us with the changes in tissue which are produced by the disease process, likewise the changes which result from it; but the gap between these two has been left unbridged. It can be bridged successfully only by an understanding of biochemistry and pathological physiology.

After many years of close study, we are confronted with many facts which we are unable to explain; largely because our field of investigation has been too narrow...

From an Article on "Intranasal Cosmetic Surgery, with Special Reference to Rib with Cartilage, and Cartilage Transplants," by Grant Selfridge, M.D., San Francisco. —Intranasal Cosmetic Surgery, especially the transplantation of cartilage and portions of rib with its cartilage in saddlenose, partial or complete, and in notched deformities of the nose and in collapse of the alae, has been a subject of great interest to me since I had the opportunity of seeing the work of Doctor Wesley Carter of New York City, five years ago. Through the courtesy of Dr. Frank Ainsworth, chief of the Southern Pacific Hospital, I have been able during my services at that hospital to work out the technique in the various deformities in which the transplant of bone and cartilage is indicated. . . .

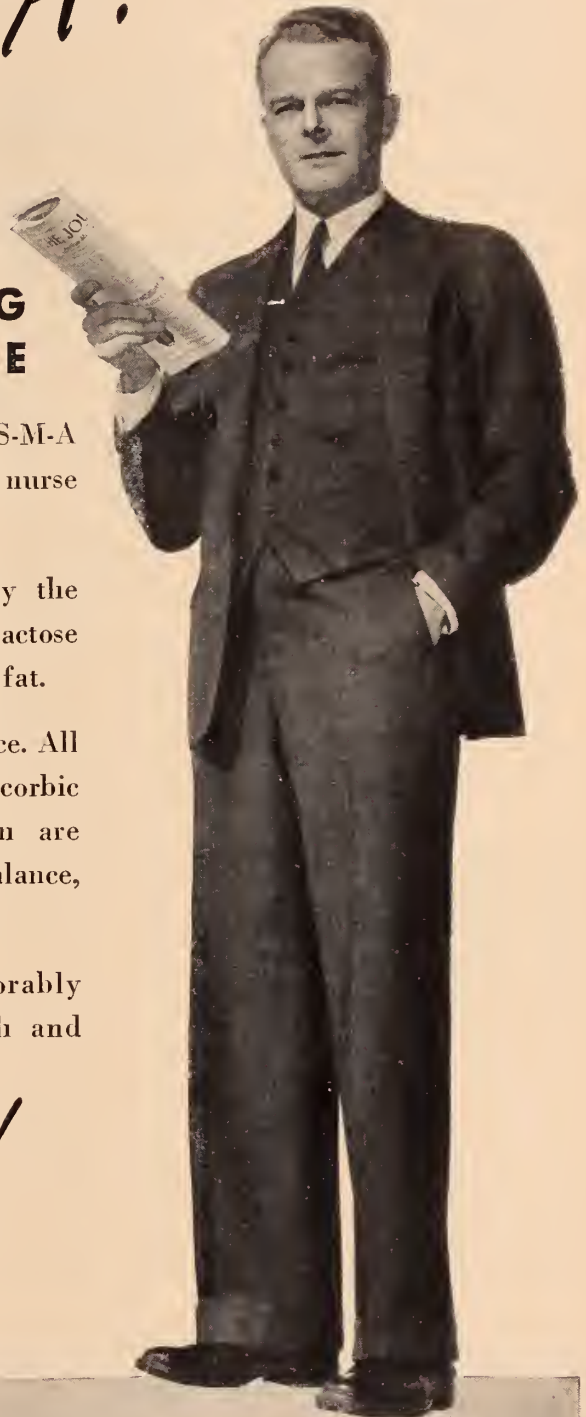
(Continued on Page 28)

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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

From an Article on "Diagnosis and Treatment of Acidosis, Especially in Diabetes," by **Albert H. Rowe, M.S., M.D., Oakland.**—It has been known for a long time that the reaction or H-ion (H) concentration of body fluids remains practically constant, in spite of the normal production of many metabolic acids and the ingestion of the alkaline and acid foods. Through the work of Henderson we now know that the maintenance of this definite H-ion concentration is due to the buffer action, or alkali reserve of the blood, along with the elimination of acids by the lungs and kidneys. He has shown that this buffer action is largely due to the carbonates of the plasma and to a less extent to the phosphates of the corpuscles. . . .

From an Article on "The Etiology of Pellagra," by **J. E. Jennison, M.D., San Diego.**—Pellagra is of more than academic interest to physicians residing in San Diego, as may be evidenced by the fact that I alone have seen at least nine cases of this malady during the last six years.

The etiology of pellagra has been as elusive as the Irishman's flea, of which he remarked, "Ye put yer finger on it and it ain't there." I will not attempt to review in detail the various theories which have been advanced, as that would make my paper far too lengthy for one evening's consideration. I will, however, refer to some of them very briefly, and then lead up to certain observations of my own; and from these I will venture my personal opinion as to the probable etiology. . . .

(Continued on Page 30)

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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

From an Article on "Malingering; Its Diagnosis and Significance," by Joseph H. Catton, M.D., San Francisco.—Malingering is the act of knowingly pretending the presence or the absence of disease; of knowingly causing disease; or of knowingly protracting an existing disease; the disease being referred to the person himself....

From an Article on "Some Heart Problems Suggesting the Necessity for a Closer Alliance Between the Physiologists, Biochemists and Clinician," by Wm. Watt Kerr, M.D., San Francisco, Professor of Clinical Medicine, University of California.—For at least five years physiologists have agreed that lack of oxygen in the blood is rarely a stimulant to the respiratory center, but that the very slightest increase of carbon dioxide, resulting from any increase in the body processes, at once augments the rate and depth of respiration to such an extent that the additional inspired air furnishes enough oxygen to supply the new demand. Nevertheless, the great majority of clinicians still explain the symptoms of cardiac dyspnoea, and base their treatment on the older supposition....

From an Article on "The Abortion Evil in a Small Town," by Wm. B. Smith, M.D., Randsburg.—Probably the abortion evil is no greater in the small town in proportion to the number of inhabitants, than in the city, but it is certainly more conspicuous, and knowledge of the usual methods used to produce abortion seems to be almost universal among the women of this small town....

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 340)

charged with murder. He maintained that Mrs. Tarleton had insisted on an anesthetic before undergoing a physical examination and had died under the ether. . . . (Los Angeles Examiner, Sept. 18, 1942.)

"Dr. A. B. Brown, chiropractor, with offices at 2561 East Colorado Street, was held to answer to Superior Court on a felony illegal operation charge following preliminary hearing yesterday. Justice of the Peace J. Russell Morton allowed the \$1000 bail on which Dr. Brown has been at liberty since her arrest, to remain in effect. . . ." (Pasadena Post, Sept. 11, 1942.)

"Two private hospital owners were ordered today to appear before the state board of medical examiners

at Sacramento, Oct. 20, to answer charges that they failed to check the credentials of 'Doctor' Arthur Osborne Phillips, bogus physician." (Oakland Post-Enquirer, Oct. 8, 1942.)

"Isaiah Conway, 50, Sacramento Indian, pleaded guilty late yesterday in the justice court of Judge K. Floyd to a charge of practicing medicine without a license and was fined \$200. He paid the fine. . . ." (Modesto Bee, Sept. 25, 1942. Prior entries, December, 1939, Jan., 1940.)

"Dr. W. E. Glaeser, 57-year-old San Francisco doctor, who was found guilty of drunk-driving by a Martinez police court jury last week, Monday paid a fine of \$135 levied by Judge Tom Meehan, and waived an appeal. At the same time he relinquished his operator's license to

(Continued on Page 34)

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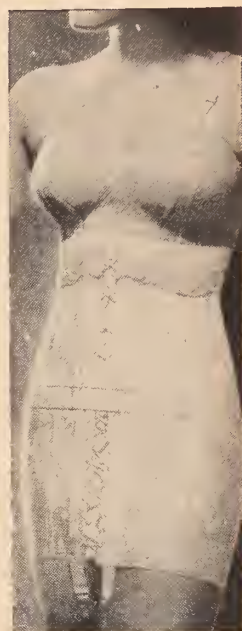
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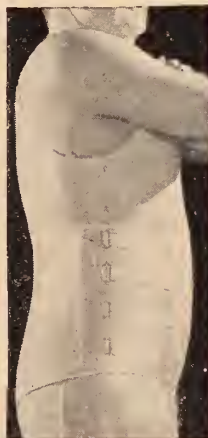


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(Continued from Page 32)

the Court, for forwarding to Sacramento, where the Motor Vehicle Department can issue him a probationary certificate. Glaeser, who has offices at 196 Guerrero Street, was accompanied by his attorney, James F. Hoey, and his nurse, Miss Jean Wilson, who testified in his behalf at the trial. The doctor did not expand upon his previous trial comment that he would not hereafter keep his yacht at the Martinez Harbor, if he 'got arrested for driving on Martinez streets.' He was arrested last December on an intoxicated driving charge, which was reduced to reckless driving, paying a \$50 fine. His second arrest was in May, when he was picked up driving along the highway to the city wharf. City Attorney Ralph H. Wight acted as prosecutor for the city." (*Pittsburg Post-Dispatch*, July 1, 1942.) (Previous entries, *News Items, California and Western Medicine*, May and July, 1942.)

"Dr. James F. Petrie, 38, today surrendered to police here on a charge of murder preferred against him following the death from an alleged illegal operation last November on Angelka Gogich, 18-year-old dancer. The doctor gave himself up to Detective Lieutenants H. F. Fremont and Jack McCreadie, but refused to make any statement. Miss Gogich, known professionally as Rose Ann Rae, died in a Glendale hospital following an operation assertedly performed in Dr. Petrie's office. Al Mathes, Hollywood sports figure, was taken into custody in connection with the girl's death, but was later released when police failed to locate Dr. Petrie." (*Los Angeles Herald-Express*, March 30, 1942.) He is mentioned in the *Los Angeles Examiner* of November 23, 1941, as a "local chiropractor."

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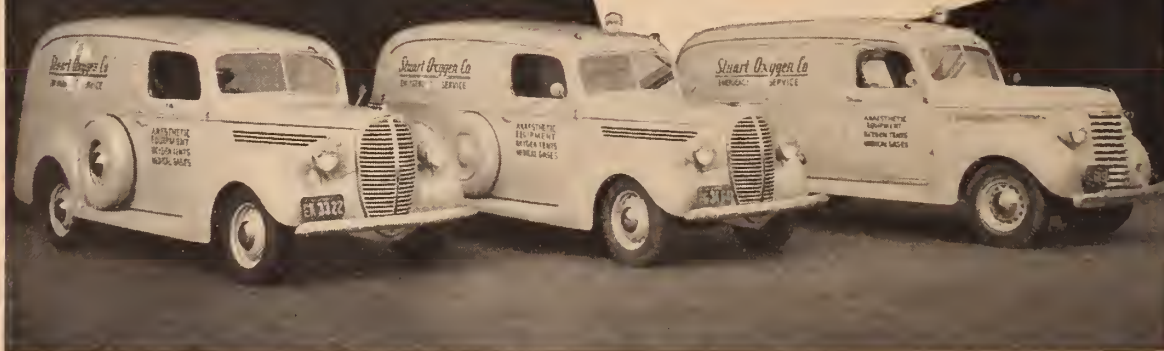
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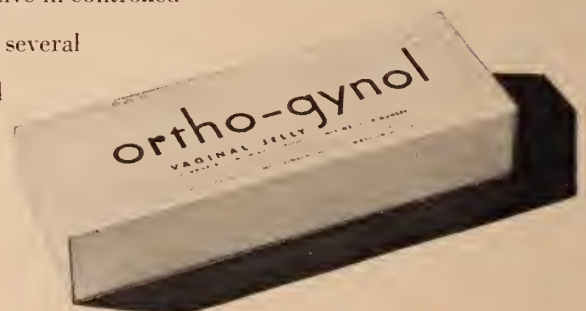
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¹Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J., and Wigodsky, H. S.: *Aluminum Phosphate in the Therapy of Peptic Ulcer*, *Arch. Int. Med.* 67: 563-578 (March) 1941. *Reg. U. S. Pat. Off.



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First District—Imperial, Orange, Riverside, San Bernardino and San Diego Counties, Calvert L. Emmons (1944), 206 Emmons Building, Ontario.	Fifth District—Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties, R. Stanley Kneeshaw (1945), 404 Medico-Dental Building, 241 E. Santa Clara Street, San Jose.	Ninth District—Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties, John W. Green (1943), Box 539, Vallejo.
Second District—Los Angeles County, Donald Cass (1945), 5300 Hollywood Boulevard, Los Angeles.	Sixth District—San Francisco County, John W. Cline (1943), 1020 Medico-Dental Building, 490 Post Street, San Francisco.	Councilors-at-Large
Third District—Inyo, Kern, Mono, San Luis Obispo, Santa Barbara and Ventura Counties, Harry E. Henderson (1943), 1421 State St., Santa Barbara.	Seventh District—Alameda and Contra Costa Counties, Frank R. Makinson (1944), 426 Seventeenth Street, Oakland.	Sam J. McClendon (1945), 2654 Fourth Avenue, San Diego.
Fourth District—Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties, Axel E. Anderson (1944), Medical Group Building, 1759 Fulton Street, Fresno.	Eighth District—Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties, Frank A. MacDonald (1945), 822 Medico-Dental Building, 112½ Eleventh Street, Sacramento.	Edwin L. Bruck (1945), 384 Post Street, San Francisco.
		Captain Philip K. Gilman (1944), 703 Market Street, San Francisco.
		E. Earl Moody (1944), 829 South Alvarado Street, Los Angeles.
		Dewey R. Powell (1943), Room 501, 242 No. Sutter Street, Stockton.
		Edward B. Dewey (1943), Professional Building, 65 No. Madison Avenue, Pasadena.

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Executive Committee			Committee on Publications		
The President, the President-Elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Past President, the Secretary-Treasurer (ex officio), and the Editor (ex officio). Henry S. Rogers, Chairman; George H. Kress, Secretary.			George W. Walker (Chairman).....	Fresno	1943
			F. Burton Jones	Vallejo	1941
			Francis E. Toomey.....	San Diego	1945
			Secretary and Editor ex officio		
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Frank R. Makinson.....	Oakland	1943	Anthony B. Diepenbrock.....	San Francisco	1945
			President and President-Elect ex officio		
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Edwin L. Bruck.....	San Francisco	1944	H. R. Madeley (Vice-Chairman).....	Vallejo	
Clarence E. Rees.....	San Diego	1945	Committee on Scientific Work		
Committee on Health and Public Instruction			George H. Kress, Chairman (ex officio, Association Secretary)		
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C. M. Birchfield.....	San Jose	1945	Howard F. West.....	Los Angeles	1945
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Morton R. Gibbons (Chairman).....	San Francisco	1944	J. Norton Nichols (ex officio, Secretary, Section on Surgery)		
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Robert A. Peers.....	Colfax	1945	The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Donald Cass, the secretary is Mr. John Hunton.		
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Walter Rapaport.....	Mare Island	1944	Lewis A. Alesen...Chair., Com. on Membership and Organization		
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George H. Sanderson.....	Stockton	1943	Francis J. Rochex.....Chair., Com. on Postgraduate Activities		
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(Continued on Page 5)

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2404 Broadway, Oakland
President, Safford A. Jelte, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, C. C. Landis, First National Bank Building, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Walter L. Taylor, 100 Pine Street, Martinez.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Lester R. Nielson, 1157 Fulton Street, Fresno.
Secretary, J. E. Young, 409 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Max J. Goodman, 525 7th Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Philip Hodgkin, Box 1178, El Centro.
Secretary, Floyd A. Burger, Box 193, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
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Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. Headen Inman, 501 Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeisner, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
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Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, George D. Wells, 4317 Downey Road, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, John C. W. Taylor, 1010 B Street, San Rafael.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

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President, Edward A. Macklin, P. O. Box 176, Kelseyville.
Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

* Deceased.

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Winton F. Swengel, 499 Pacific Street, Monterey.
Secretary, Arnold Manor, 578 Polk Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
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Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

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Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
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Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Henry L. Saverien, 2626 L Street, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
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Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, John W. Cline, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

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Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Deon A. Crew, 748 Marsh Street, San Luis Obispo.
Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
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Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
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Secretary Pro-Tem, John Hunt Shepard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, M. D. McPherson, Vine and Church Streets, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
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Shasta County Medical Society
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Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
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Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, Oakdale.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

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Secretary, O. T. Wood, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
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Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

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Meeting, *Second Tuesday, Ventura County Country Club.*

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Secretary, Austin M. Clark, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

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Sacramento—1020 N St., Phone 2-4711.	Los Angeles, 906 State Building.	
Los Angeles—State Office Building, 217 West First Street, MADison 1281.	Sacramento, Business and Professional Building, 1020 N Street.	Medical Schools of California
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California Northern District Medical Society	Southern California Medical Association	Stanford University School of Medicine, 2398 Sacramento Street, San Francisco.
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BOOK REVIEWS

BOOKS RECEIVED

Medical Bulletin University of Cincinnati, Volume IX; Extra-Mural Teaching of Preventive Medicine and Public Health. By Alfred Korach, M.D., Lecturer in Preventive Medicine, University of Cincinnati College of Medicine. Paper. Pp. 143. University of Cincinnati, 1942.

Eat What You Want! A sensible guide to good health through good eating. By W. W. Bauer, M.D., Director, Bureau of Health Education, American Medical Association, Associate Editor "Hygeia"; and Florence Marvyn Bauer, with an introduction by Morris Fishbein, M.D. Cloth. Price \$2.00. Pp. 263. New York: Greenberg, Publisher, Inc., 1942.

A Venture in Public Health Integration. The 1941 Health Education Conference of the New York Academy of Medicine. Cloth. Pp. 56. Price \$1.00. New York: Morningside Heights. Columbia University Press, 1942.

Gregg Medical Shorthand Manual. Second Edition. By Effie B. Smither. Cloth. Price \$2.00. Pp. 191. New York, Chicago, Boston, San Francisco, London: The Gregg Publishing Company, 1942.

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Books Received:

August, adv. p. 7; September, adv. p. 7; October, adv. p. 7; November, adv. p. 7; December, adv. p. 7.

Books Reviewed:

July, adv. p. 7; August, adv. p. 17; September, adv. p. 10; October, adv. p. 13; November, adv. p. 10; December, adv. p. 7.

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Lessons from Pearl Harbor

Destruction of barracks at Wheeler Field, T. H., December 7, 1941.
Photo by U. S. Army Signal Corps.

OUT of the chaos and confusion—the burns, lacerated wounds and compound fractures—that was Pearl Harbor on that first Sunday of December, 1941—have come many lessons. Not the least among them is the value of the sulfonamides—used topically for the management of the potentially infected traumata.

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tice but in industry and civil life. These compounds should be regarded as an important adjunct to surgery, regardless of whether the surgeon is dealing with grossly contaminated wounds or maintaining asepsis in his operative field. Further studies must, of course, be made to determine the method of application best suited for each type of wound.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 396)
the infective intestinal type—typhoid, paratyphoid, dysentery, and cholera; or (b) those conveyed by vermin—typhus and plague.

As these diseases and their specific organisms are the same as those met with in peace, the high disease rate of troops on active service may be either due to the lowered resistance of the troops, or to increased facilities of infection. The reason for these increased facilities is easily understood. . . .

From an Article on "Urological Problems," The Chairman's Address, by Victor G. Vecki, M.D., San Francisco.—There was a time, and not so very long ago, when urology was considered to be a parvenu amongst the

medical specialties. This time, however, is gone for good, and our specialty is occupying its proper place definitely. Some of our shining lights seem to think that the receiving of urology into polite medical society circles is simply due to the circumstance that the original genito-urinary surgeon became a urologist, and the kidney, the ureters and the bladder were given all the prominence while the genitalia proper, their contagious and other pathological conditions were ignored or at least soft-pedaled. . . .

From an Article on "Surgical Treatment of Seminal-Vesiculitis," by Arthur B. Cecil, A.B., M.D., Los Angeles.—The part played by the seminal vesicles as a seat of chronic infection has until recently practically escaped

(Continued on Page 14)

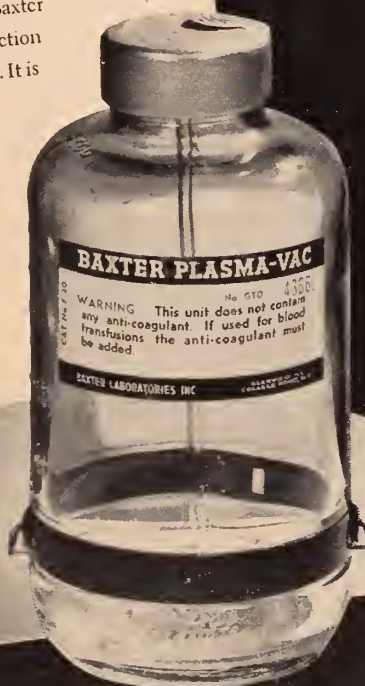
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Minute Man Flag Awarded.—In recognition of more than 95 per cent participation in the Federal payroll savings plan, a Minute Man Flag has been presented to the Ciba Pharmaceutical Company of Summit, N. J., by the United States Treasury Department War Savings Staff.

The presentation was made by W. H. Hassinger, Deputy Administrator of the War Savings Staff, and a speech of acceptance was delivered by J. J. Brodbeck, Executive Vice-President and General Manager of Ciba.

Two employees of the company, Alice Christensen and Carmello Terranova, accepted the flag from Mr. Hassinger in behalf of Ciba.

In responding to Mr. Hassinger's presentation address, Mr. Brodbeck described the need for "a complete and unselfish dedication of all our efforts to the successful

prosecution of the war on the home front."

Americans today, Mr. Brodbeck warned, must work "not only for our own good but for the good of all." He urged continued participation in the war savings program by all Ciba employees.

Ciba's chemical manufacturing department received an individual Minute Man banner with a rosette. In making this award to Donald Mundwiler of the department, Mr. Brodbeck said that its employees were contributing more than 10 per cent of their total earnings each week. This was the first of the Ciba departments to attain this goal.

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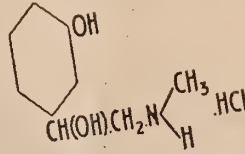
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* In Military Service

TWENTY-FIVE YEARS AGO

(Continued from Page 10)

the attention of the surgical world and it is only now that urologists are in the midst of solving, not only the pathology, but even the physiology of these organs. . . .

From an Article on "Better Teaching in Schools of Nursing," by Anna C. Jammé, R.N., Director Bureau Registration of Nurses.—The problem surrounding the education and training of nurses in schools of nursing in this state have been claiming attention in the past few years and more particularly since the publication of a curriculum for schools of nursing by the State Board of Health. . . .

From an Article on "Social Insurance," by N. R. H. Juell, M.D., Santa Rosa.—It is time for the medical profession to wake up to the realization that universal insurance against sickness, maternity and old age is coming, so that the movement will not catch us napping. as did the industrial insurance act, the unsatisfactory features of which could easily have been avoided if we had taken the trouble to study the history of this world movement and the lesson taught by countries where it has been tried out.

Insurance against accident and sickness was left to private corporations, lodges and insurance companies, until in '83, when the government of Germany took the first step to organize it into a national system. Other countries followed, so that today almost every civilized nation has adopted some form of industrial or sickness insurance, the systems varying greatly as all is yet in an experimental stage. . . .

(Continued on Page 16)

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TWENTY-FIVE YEARS AGO

(Continued from Page 14)

From an Article on "Protecting Soldiers from Venereal Diseases."—Dr. H. G. Irvine, director of the newly established Bureau of Venereal Diseases of the California State Board of Health, conferred with Surgeon-General Gorgas and Major W. F. Snow, who has charge of venereal disease control in the Army. As a result of this conference, the Bureau is placed in close contact with the War Department in its widespread work of safeguarding the health of our soldiers. California is recognized by the War Department as the first State to establish a bureau for taking direct and positive action in the control of venereal diseases. A definite policy in the control of venereal diseases among soldiers and sailors has been established by the Army and Navy. With the cooperation of states, counties and cities excellent results may be expected. It is an acknowledged fact that the most serious health problems in modern armies are those relating to the venereal diseases. Every army of Europe has suffered immensely because large numbers of their men have been incapacitated by venereal diseases. To win the war our men must be fit, and California cannot send men infected with venereal diseases to the front. . . .

From an Article on "A Review of Some of the Later Developments Along Immunological Lines," by R. A. Archibald, D. V. S., Oakland.—In reviewing recent literature we are impressed with the fact that we are entering a new era in the study and treatment of infectious diseases.

When the vaccine therapy was first introduced by Wright and his coworkers, we were quite enthusiastic, forming at that time strong opinions on specificity and

(Continued on Page 17)

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

believing that all infectious diseases should be treated solely upon a specific basis. Through later studies, however, and taking into consideration the work of Abderhalden, Ehrlich, Vaughan, Jobling, Petersen and others, our opinions as to specificity have undergone decided modifications, so that even though we still believe specificity must be observed in following out vaccine therapy in the treatment of infectious diseases, we do not believe that specific treatment is the sole or even the main factor. . . .

Los Angeles County: Dr. H. Bert. Ellis, a Trustee of the A. M. A.—At the last meeting of the American Medical Association, Dr. H. Bert. Ellis of Los Angeles was honored by being elected a member of the Board of Trustees of the A. M. A.

This Board has in its keeping the enormous professional and financial interests of the A. M. A., and a trusteeship is one of the very highest honors in the gift of the Association.

This election is a distinct recognition of the many years of faithful work by Dr. Ellis in behalf of organized medicine.

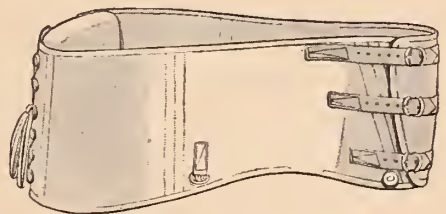
STATE BOARD OF MEDICAL EXAMINERS

Prosecution of Illegal Practitioners.—Experience has proved that the expense of conducting the legal department of the Board of Medical Examiners has been a heavy drain on the finances, yet as long as violations

(Continued on Page 18)

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TWENTY-FIVE YEARS AGO (Continued from Page 17)

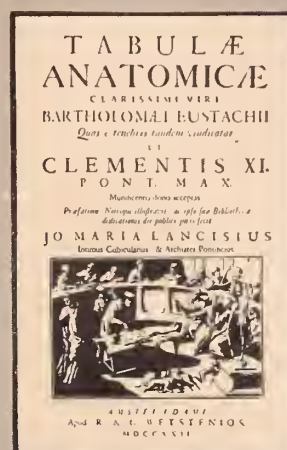
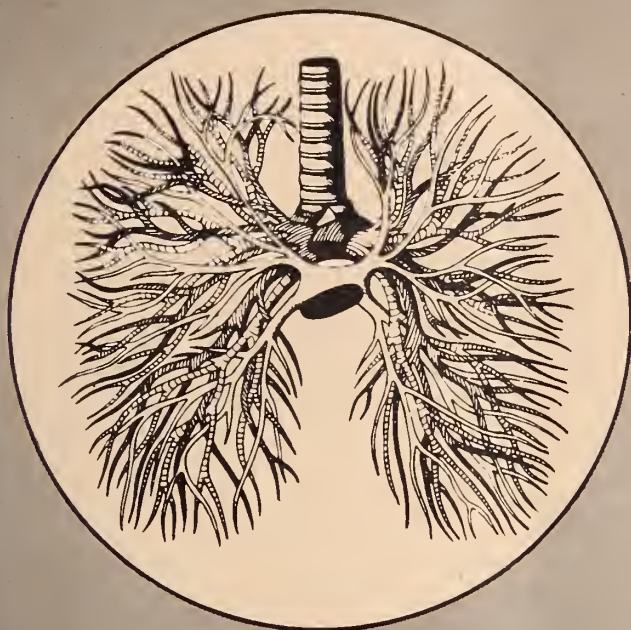
exist the board is called upon to discourage such violation and the procedure incident thereto demands a considerable financial expenditure. A complexity of circumstances renders the details relative to the enforcement of the penalty of violation of the medical act most difficult, and at the same time most expensive. The indifferent support by the medical fraternity in a specific section of the State renders prosecution work most difficult and a heavy drain on the finance of the board is the natural sequence. Let us follow the steps incident to the investigation and prosecution in a specific section of the State from which emanates a number of communications complaining of the alleged violation on the part of some specific individual. . . .

From an Article on "Urological Diagnosis in General Practice," by Frank Hinman, M.D., San Francisco.—

The recognition, at an early stage of almost any urological disease, whether in man, woman or child, and immediate institution of proper treatment would give a high percentage of complete cures; would prevent many chronic and hopeless complications, and would greatly lower mortality. Many urological conditions may be recognized without the need of any special procedure of examination. In the majority, however, particular methods are required before a diagnosis can be made. It is the purpose of this paper to call attention to the value of a properly performed routine urological examination on the part of the general practitioner, which will enable him not only to diagnose earlier those conditions possible

(Continued on Page 20)

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● From the rare volume, "Tabulae Anatomicae" by Bartholomaei Eustachii, comes this interesting illustration of the bronchi, arteries and veins of the lungs. Published in 1722.

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

of diagnosis by such an examination, but also to refer at an earlier date particular cases requiring a more complete urological study. . . .

From an Article on "Treatment of Eclampsia of Pregnancy with Some Case Reports," by Edward N. Ewer, M. D., F. A. C. S., Oakland.—By this term is meant the toxæmia which presents some or all of the following signs: albuminuria, headache, disturbances of vision, high blood pressure, epigastric pain, nausea and vomiting, edema and finally convulsions. It has been suggested that accidental hemorrhage may be added to this list, for if eclampsia without convulsions can cause cerebral apoplexy, it may be suspected that it can also cause retroplacental hemorrhage. Albuminuria has often been found in association with this variety of hemorrhage.

The enormous mortality, when convulsions supervene, places this condition at once among our most formidable diseases. . . .

From an Article on "Recruiting Observations," by Jay Jacobs, M. D., San Francisco, and W. D. Horner, M. D., San Francisco, Assistant Surgeons, U. S. Naval Reserve Force, Headquarters 12th Naval District, Sheldon Building, San Francisco.—The following observations are taken from the records of 3,460 men examined in San Francisco, California, for the United States Naval Reserve Force.

All of the applicants were subjected to the same physical examination, regardless of rating or duties to be performed.

Of the above number 833, or 24 per cent, were rejected for various causes.

The percentage of rejections in this series is lower than the figures given by Gatewood in his "Naval Hygiene," who states that of 81,442 applicants examined during 1903, 29,910, or 36 per cent, were rejected for physical disability. However, 26,242 more were rejected for causes other than declared physical disability, so the final percentage of rejections must be given as 67 per cent or approximately two out of every three applicants in that series.

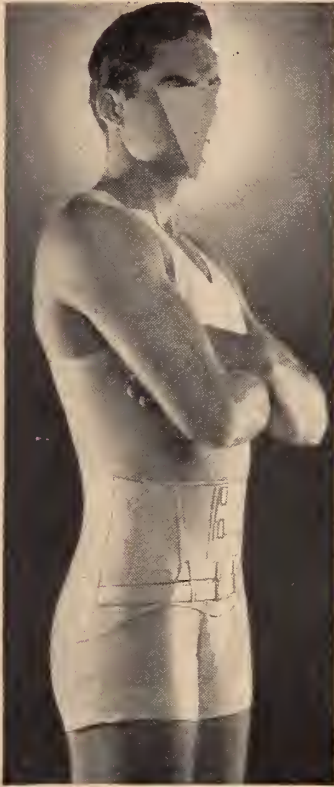
From an Article on "Radium: Its Local Application as a Therapeutic Agent—With Case Reports," by Rex Duncan, M. D., Los Angeles.—Radium is an element which owes its therapeutic properties to certain rays, which during the process of its disintegration are being constantly and continuously emitted. These rays, known as alpha, beta and gamma rays, differ in their penetration, chemical and physical characteristics, and in their effect upon body tissues.

"Most families have a tale of the Exorbitant Physician. There is such a creature. But there is also the physician who comes home tired out after a long day, to wonder where he can scrape enough money together to meet his office rent. In his behalf, we would urge the obligation, sanctioned by all law, human and Divine, to pay one's debts as promptly as possible."

If one leaves his radio or his automobile in a repair shop, he is well aware that he cannot take it out without the bill being paid. As physicians we are repair men of the human body, a machine far more intricate than any ever devised by man, but the same individuals who pay other bills so unhesitatingly allow the doctor's bill to drag on for months and even for years. No one can honestly deny a physician the same right to prompt payment enjoyed by mechanics.—F. C. S., in *Philadelphia Medicine and Medical Digest*, Vol. 37, No. 25.

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 396)

vestigation by Special Agent Joseph Williams of the State Medical Board." (San Francisco Chronicle, November 4, 1942.)

"Dr. Ernest B. Mundkowski, San Diego physician, yesterday was named defendant in a suit brought in United States court here to cancel his citizenship on the ground he is still loyal to Germany and an admirer of Hitler. The suit charges that Dr. Mundkowski frequently declared 'Hitler wouldn't wipe his feet on the United States.' Assistant U. S. Attorneys James L. Crawford and John Marvin Dean said he has also been active in the now defunct German-American Bund. The physician became naturalized in 1928." (Los Angeles Times, October 28, 1942.) The files of the Board of Medical Examiners do not indicate anyone by this name licensed by this Board to practice in California. Our files indicate that in 1926 he was connected with the Clinical Laboratory as a laboratory technician at 350 Post St., San Francisco.

"Federal charges of impersonating an officer of the United States may be filed against 'Dr. Phillips' of Chico, who is serving a sentence in the Butte county jail on State charges of practicing medicine without a license and carrying firearms. 'Dr.' Phillips is Arthur Osborne Phillips, and was a former member of the staff of the Enloe Hospital in Chico. Dr. Enloe, owner of the hospital, was summoned this week for further inquiry into the case of the man who acted as a doctor in Chico and at the Brush Creek CCC camp for months before

(Continued in Back Advertising Section, Page 26)

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Christmas will have little meaning to the thousands of physicians
who serve their country and perhaps to thousands more
who strive to carry on at home. There is little time
for exchange of pleasantries in the grim business of winning
a war ☆ But the Christmas Season will come
again when the forces of evil are dead—when man again
will do unto others as he would have done unto him.

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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 57

DECEMBER, 1942

NO. 6

California and Western Medicine

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Roster of Editorial Board appears in this issue at beginning of
California Medical Association department. (For page
number see index below.)

Advertisements.—The Journal is published on the seventh of
the month. Advertising copy must be received not later than the
fifteenth of the month preceding issue. Advertising rates will
be sent on request.

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Subscriptions may commence at any time.

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both the old and new address. No change in any address on
the mailing list will be made until such change is requested by
county secretaries or by the member concerned.

*Responsibility for Statements and Conclusions in Original
Articles.*—Authors are responsible for all statements, conclusions
and methods of presenting their subjects. These may or may not
be in harmony with the views of the editorial staff. It is aimed
to permit authors to have as wide latitude as the general policy
of the Journal and the demands on its space may permit. The
right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted
for publication on condition that they are contributed solely to
this Journal. New copy must be sent to the editorial office not
later than the fifteenth day of the month preceding the date of
publication.

Contributions—Length of Articles; Extra Costs.—Original
articles should not exceed three and one-half pages in length.
Authors who wish articles of greater length printed must pay
extra costs involved. Illustrations in excess of amount allowed
by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND
WESTERN MEDICINE has prepared a leaflet explaining its rules re-
garding publication. This leaflet gives suggestions on the prepa-
ration of manuscripts and of illustrations. It is suggested that
contributors to this Journal write to its offices requesting a copy
of this leaflet.

DEPARTMENT INDEX

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EDITORIALS

A TWO-DAY, STREAMLINED ANNUAL SES- SION OF C.M.A. WILL BE HELD IN LOS ANGELES, MAY 2-3, 1943

**Hotel Del Monte Becomes a Pre-Flight
Naval School.**—At the Council meeting held
on September 13th, the Councilors tentatively
agreed that it might be possible to hold a three
day session (Monday, Tuesday, and Wednes-
day), at Hotel Del Monte, in accord with the
action of the House of Delegates in May last;
provided, complications did not arise.

However, such a complication came into the
picture when, on December 5th, newspapers an-
nounced that, by the end of this year, Hotel Del
Monte would be taken over by the U. S. Navy as
a Pre-Flight School—an action confirmed by
letter from the hotel management.

At a meeting of the C.M.A. Executive Com-
mittee, held on December 6th, this item was given
place among the agenda. The Executive Com-
mittee recommended to the Council, in view of exist-
ing conditions, that next year's annual session be
limited to two days, commencing on Sunday,
May 2nd, and adjourning on Monday, May 3rd,
1943; and that headquarters should be at Hotel
Biltmore in Los Angeles. This recommendation
has since been approved by mail vote of the
Council.

* * *

General Plan of the Two-Day Session.—
Some brief comment on the general plan, in re-
lation to meetings of the Scientific Assembly
(General and Section Meetings) and the House
of Delegates:

The first meeting of the House of Delegates
will be called to convene at noon on Sunday, May
2nd, and the second meeting at 1:00 p.m., on
Monday. This arrangement will permit the lapse
of twenty-four hours between hours of *convening*,
to conform to by-law provisions. (If the first
meeting does not begin its work until 2:00 p.m.,
or so, the by-law provision will still have been
observed.)

Two Scientific Meetings will be held, the
first on Sunday, May 2nd, to begin probably at
9:00 a.m., and the second on Monday morning,
commencing at the same hour.

The twelve Scientific Sections (General Medi-
cine, General Surgery, Obstetrics and Gynecology,
Eye-Ear-Nose and Throat, Anesthesiology, Der-
matology and Syphilology, Industrial Medicine

and Surgery, Neuropsychiatry, Pathology and Bacteriology, Pediatrics, Radiology, and Urology) will hold meetings on Sunday, May 2nd, commencing at 1:30 p.m. During this period it will be possible for each Section to present four or five papers, and elect officers for the succeeding year. Several of the larger sections may wish to also hold meetings on Monday afternoon. This program will permit the official journal, CALIFORNIA AND WESTERN MEDICINE, to come into possession of a supply of up-to-date papers on topics of pertinent medical interest and value.

The established custom, of a Dinner to the President, will probably be followed, the banquet, open also to wives and guests, to be held on Sunday evening.

Affiliated Societies, which in the last several years have been meeting at Del Monte on the Sunday immediately preceding the annual session, will be obliged, owing to lack of meeting room accommodations, to hold their sessions on Saturday, May 1st, or Monday afternoon, the third, or Tuesday, May 4th.

* * *

C.M.A. Headquarters will be Hotel Biltmore.

—The headquarters of the session will be the down-town Hotel Biltmore at Fifth and Olive, opposite Pershing Park. This hotel is not far distant from the depot, and may be conveniently reached through streetcar accommodations, if taxi service is not available. Its meeting-room facilities are comparatively good; and in the near vicinity are many parking lots. Concerning such items, full information will be given in due course of time.

* * *

Nature and Scope of Scientific Programs.

Wartime medicine, with emphasis upon the three phases which have so sharply differentiated themselves during the last year (military, essential industry, and civilian) will receive emphasis. Advances in medical science, as brought out in these aspects, and general and specialty medicine likewise will receive attention. Also, careful consideration will be given to other features, such as medical and surgical films, and scientific and various exhibits. There will be no display of commercial or technical exhibits in 1943.

* * *

Registration May Be Large.—The arrangements, as outlined, will permit the California Medical Association to carry on its work without interruption, avoiding lapse of an annual session—but with due consideration of the stress and strain of present-day practice. It follows that the attendance from county societies throughout the State will not be as great as in recent years, but with the large membership of Los Angeles County (2825 members), it is possible that, after all, the registration, at least on Sunday, May 2nd, may be very large.

The hope is expressed, therefore, that members throughout the State, who can arrange their work,

will make an earnest effort to be present at this two-day, streamlined annual session of year, 1943.

THE STATEWIDE MEDICAL SERVICE— CALIFORNIA PHYSICIANS' SERVICE— TAKES OVER GOVERNMENTAL CON- TRACTS (RURAL HEALTH AND WAR HOUSING PROJECTS)

Some Past History.—California physicians who have maintained interest in the efforts of Organized Medicine to solve some of the economic and other problems connected with the task of making available an adequate medical service to citizens who belong to lower income groups, are somewhat familiar with the trials and tribulations encountered by the California Medical Association, in placing the state-wide medical service—California Physicians' Service—on a sound financial basis.

The decision to form such an organization under the sponsorship of a constituent state medical association came only after proposed plans had been a subject of serious consideration and discussion at regular and special meetings of the House of Delegates of the California Medical Association; those efforts having commenced in very active form at the Riverside Annual Session in year 1934.

When finally launched on its course, the new nonprofit organization for medical service glided into the waters on a plan that incorporated full coverage service—although the infant organization had only a very limited capital in dollars and cents, and an underwriting group in the form of California physicians who were willing to give professional services on a unit basis—a set-up which experience proved to be too idealistic, to be actuarially or, rather, financially sound for a medical service program, so extensive in scope.

* * *

Contract Changes Brought about through Experience.—In due course, at the end of one, two and three years of operation, it was found necessary to trim the contracts, through procedures that would cut out avoidable and consequent over-head and expense.

Members of the medical profession need not be reminded that the hardships of unforeseen and unpredictable illness and injury are related, not to minor, transient conditions, but rather to major diseases and injuries that require extensive medical or surgical care and hospitalization. It is in these latter cases that illness and injuries can result in catastrophe to individual and family savings and happiness.

Accordingly, in due time, as announced by California Physicians' Service, plans were put into operation whereby full-coverage contracts should be discontinued, until perhaps some future day when sufficient reserves will warrant. Within the next six months, all full-coverage contracts still existing will have been completed.

Today deductible contracts (contracts in which the first two visits for an illness must be personally paid by the patient), and limited surgical contracts (for specified surgical procedures), are the only forms that are being sold to eligible groups on the prepayment basis.

* * *

A Creditable Career.—California Physicians' Service, as regards attainment of all its initial objectives, has not been entirely successful. However, in the face of great obstacles, C.P.S. has made real progress, and with the continued good will and coöperation of the physicians of California, should be able to demonstrate that Organized Medicine can carry through, to success, a state-wide medical plan; and also, at the same time, compensate its underwriters—the professional members—with unit payments of fair value. When these two achievements are realized, the large mass-spread of beneficiary members will then permit the accumulation of adequate reserves, to provide also for epidemic or other unforeseen expenses.

To recall the progress of C.P.S.: In September, 1939, it had 1,220 beneficiary members; in December, 1940, 20,993 members; in December, 1941, 32,562 members; and at the present time, it has 37,871 beneficiary members.

It should be kept in mind, however, that the decision to discontinue the sale of full-coverage contracts, necessarily resulted in loss of a considerable number of members, with resultant retardation of increase in unit values to professional members.

It was unfortunate that some of the conditions which came into being during the last three years of operation created confusion, and added to sales management difficulties, so that a number of desirable coverages, involving possible acquisition of some thousands of beneficiary members, could not be consummated. However, those experiences are as water that has gone over the dam. The reassuring element lies in the fact that, in spite of the storms which C.P.S. was forced to weather, it has come through and is maintaining itself on a self-supporting basis, and that there is assurance, when the coverage changes now being carried out are completed, it will be possible to compensate physicians who have enrolled as professional members, with stipends that will approximate the income that would have been received from the same group of patients; namely, from the beneficiary members of California Physicians' Service, had they continued as individual patients in regular private practice.

* * *

More Recent Activities of C.P.S.: Provision of Medical Service in Federal Rural Health and Housing Projects.—C.M.A. members who are in the habit of reading the information presented in the California Physicians' Service department which appears in each issue of CALI-

FORNIA AND WESTERN MEDICINE, may have noticed the comments concerning the trial experiments that were being carried on by C.P.S. in coöperation with Federal agencies, concerning medical service to be given in connection with Rural Health and Housing projects.*

Perusal of the items referred to will reveal to readers who are interested the picture as it exists in its present form.

It is most gratifying that the Federal Authorities who are charged with the supervision of these important governmental projects have given evidence of their faith in the capacity of California Physicians' Service to provide an adequate medical service to two important groups of citizens, through the contracts that have been made in regard to agricultural workers coming under the Farm Security Administration, and to workers in essential war industries who are living in structures erected by the Federal Public Housing Authority.

* * *

Important Announcement in Current Issue.—To bring these comments to close, members are urged to read, in CALIFORNIA AND WESTERN MEDICINE's current issue, the details concerning some of the activities now under way.† It should be heartening to members of the California Medical Association that C.P.S., the state-wide, non-profit organization for medical service they have sponsored, has been able to perform some of its functions with such beneficent end-results for certain population groups in California, who were in need of adequate medical care.

Special appreciation, therefore, is expressed by the officers of the California Medical Association to the large number of professional members whose loyal service and generous coöperation have made it possible for California Physicians' Service to carry on its work. Many of these professional members, on numerous occasions, in order to coöperate with the announced purposes of the California Medical Association, were obliged to accept financial compensation—on the unit basis—in much lesser amounts than the totals that would have been given to them by some beneficiary members who had previously been their private patients. That, by and large, the professional services were so well rendered, redounds to the credit of the individual physicians and to the medical profession as a whole. So once again, to them, and to all who have given aid, in professional service and in advice, thanks are expressed.

From now on, gradually, but increasingly brighter, the sun should shed a warmer glow on California Physicians' Service.

* For informative items in relation thereto, see issues of CALIFORNIA AND WESTERN MEDICINE: May, page 323; June, page 371; July, page 106; August, page 159; October, page 264; November, page 326; and in this current December issue, on page 380.

† See page 379.

SENATOR PEPPER HEARINGS ON PROCUREMENT AND ASSIGNMENT SERVICE

Hearing Transcript Appeared in "Journal A.M.A."—Commencing on November 2, 1942, Senator Claude Pepper of Florida, acting largely as a one-man representative of a subcommittee of the U. S. Senate Committee on Education and Labor, conducted in Washington, D. C., a rather extensive hearing, the transcript of which appeared in the November 21st issue of the *Journal of the American Medical Association*. In small type, the report of the proceedings covered some 42 pages!

Reference is made thereto because it is a question whether many physicians who receive the *Journal A.M.A.* took the time to read the lengthy testimony, a considerable portion of which deals with statements bearing on California; more particularly the "Permanente Foundation Hospital" established in the remodeled Fabiola Hospital of Oakland, and designed for medical and hospitalization service for workers in the Richmond Shipyards operated by the Henry J. Kaiser interests—the organization given credit for building cargo ships of considerable tonnage in 5 days or so, although competent authorities have stated that the man-hours used on all parts of the ship amount to calendar days of work that perhaps approximate from 30 to 60 days or more!

* * *

Hearing Received Much Newspaper Comment.—Much publicity appeared in the newspapers during the progress of the hearing. In the *Journal of the American Medical Association*, the "Pepper Hearing" received editorial comment, the issue of November 21st presenting a transcript of the testimony, from which excerpts appear in this current issue of CALIFORNIA AND WESTERN MEDICINE.* Members of the California Medical Association should be interested in reading the queries and statements made by the California physician, Sidney R. Garfield, M. D., with headquarters in Oakland, who is chief of a staff of some thirty physicians working out of the "Permanente Foundation Hospital." (News items concerning dedication of the institution appeared in CALIFORNIA AND WESTERN MEDICINE, September, page 221, and November, page 334.)

The excerpts from the testimony given by Morris Fishbein, M. D., editor of the *Journal A.M.A.*, in answer to queries put by the Senator from Florida—who, throughout the hearing, gave repeated evidence of his state of mind in relation to the National Procurement and Assignment Service, and also to the American Medical Association—furnish illuminating reading.

It is hoped that all C.M.A. members who have not yet done so will mark the items for perusal. No further comment will be made here concerning the testimony, because it speaks for itself, both in what is printed and what is evident between the lines.

* See page 360.

Permanente Hospital of Oakland: Some Excerpts from its Literature.—However, in regard to the "Permanente Foundation Hospital"* in Oakland, it may not be out of place to print, for the information of C.M.A. members, two items worthy of thought, especially when considered in relation to what has been stated above concerning the Pepper Hearings (or "Pepper Inquiry," as it was styled by Editor Fishbein).

From page 2 of an eight page illustrated brochure that was distributed to shipyard employees, through foremen and other representatives, the following quotation:

"A HEALTH PLAN

For the Employees of
the Richmond Shipyards

"This is a Health Plan.* Its primary purpose is to prevent illness through medical treatment and hospitalization for nonoccupational illnesses and accidents. To this end, First Aid stations are located in all of the yards. A Field Hospital is located at Richmond, and, for the more serious cases, services are available at the Permanente Foundation Hospital, Broadway and MacArthur Boulevard, Oakland, California.

"The medical and hospital services which you will receive under this Plan are provided by Sidney R. Garfield, M. D., who will maintain a Staff composed of more than thirty physicians and surgeons. The Staff will include specialists in the major divisions of medicine, so that each subscriber will be furnished with the attention of a specialist whenever recommended by the attending physician."

From a footnote, also on page 2, the following illuminating item:

*"This outline is a digest of the hospital and medical services which are provided under the agreement between the three Richmond Shipyards and Sidney R. Garfield, M. D., whereby Dr. Garfield has agreed to furnish medical and hospital services to the eligible employees of the shipyards who have subscribed to such services. The shipyards have agreed to make weekly deductions for the employees who have subscribed and on behalf of such employees to pay the amount deducted to Dr. Garfield. Copies of the agreement itself are on file and available for inspection by any employee at the Personnel Office in each yard." (Note. Italics by Editor.)

In connection with the footnote quoted above, the "Health Plan Application" for employees, which follows, should also take on additional significance.

(COPY)

HEALTH PLAN APPLICATION

Yard No..... Badge No.....
Name
Last First Middle

I HEREBY APPLY for participation in the Health Plan for Employees of the Richmond Shipyards, Richmond, California, and hereby voluntarily authorize my employer to deduct fifty cents each week from wages hereafter earned by me, and on my behalf to pay said

* Information has been received from the Secretary of State of California that his office has no record of a corporation of the name "Permanente Foundation."

amount for medical and hospital services as provided in the agreement providing for such services, a copy of which is on file with my employer, and a digest of which I have received.

.....
Signature

Date....., 1942

NOTE: This Plan is now available in Yards 1 and 3. Employees of these Yards may sign up immediately. The Plan will be available in Yard 2 as soon as appropriate arrangements can be made.

Would it not be in order, taking into consideration the above, for us to ask ourselves the question, What do these statements in the brochure mean, and what will be the total amount of money turned over to Sidney R. Garfield, M. D., under the above arrangements in this supposedly non-profit plan sponsored by the Kaiser interests?

Perhaps Doctor Garfield will be willing to furnish this and related information. If so, it may clarify some phases of the "Health Plan" activities that seem a bit obscure.

EDITORIAL COMMENT†

NEWER TERMINOLOGY FOR SERUM "COMPLEMENT"

The new terminology for serum complement currently suggested by Pillemer and Ecker¹ of the Institute of Pathology, Western Reserve University, may well pave the way for new or improved methods of diagnosis and treatment of infectious diseases.

Originally conceived as a single protective enzyme, the serum component known as "alexin," or "complement," was separated into two components by Ferrata.² On treatment with distilled water, fresh guinea pig serum was separated into a globulin and an albumin fraction, neither of which is capable of activating "amboceptor." If the albumin and globulin fractions are reunited, however, the original activating power is restored. It was found that the same separation into two inactive components can be effected by saturating the serum with CO₂,³ or by slight acidulation.⁴ It was afterwards shown by Whitehead,⁵ of Leeds University, that the globulin and albumin fractions thus prepared are almost invariably impure, one or both of them containing an adsorbed "third factor" essential for complement action. This "third component" is readily removed from guinea pig serum by adsorption on yeast or on zymine (insoluble residue left after repeated extraction of yeast with alcohol, ether and distilled water). The relatively pure albumin ("end-piece") and globulin ("mid-piece") are not affected by such adsorption. The "third component" is thermostable so can be obtained free from the thermolabile proteins. Added to an in-

active purified albumin-globulin mixture the "third component" restores the original complement titer.

Somewhat later, a fourth essential factor was discovered in hemolytic complement, usually existing as an adsorbed contaminant on serum albumin ("end-piece"). Gordon⁶ and his colleagues found that guinea pig serum could be inactivated by the addition of a small amount of ammonia (0.25 cc. n/6.5 NH₄OH per 1 cc.) without demonstrable injury to the end-piece (albumin), mid-piece (globulin) or "third component." The fourth factor thus destroyed is non-dialysable and relatively thermostable. It is not identical with the previously discovered "third component," since it is not adsorbed on yeast or zymine.

Hemolytic complement (C), therefore, is not a unit enzyme as postulated by earlier serologists, but a functional metaphor or immunologic abstraction, symbolizing the complex interaction of four semi-independent normal serum fractions: "mid-piece" (globulin) + "end-piece" (albumin) + "third component" + "fourth component." "Complement fixation" also becomes an archaic metaphor now mainly of historic interest.

Pillemer⁷ and his colleagues have recently added to these well-established complexities by further fractionation of these components. Electrophoretic diagrams prepared in the Department of Physical Chemistry, Harvard Medical School, for example, indicate that mid-piece and end-piece each consist of a mixture of at least four distinct serum proteins. Whether or not all eight proteins are essential for full complement action has not yet been determined. The terms "mid-piece," "end-piece," "albumin fraction" and "globulin fraction" thus also become archaic and in the opinion of Pillemer should be discarded in favor of his non-committal terminology: C₁, C₂, C₃ and C₄. The discovery of races of guinea pigs hereditarily deficient in C₃⁸ and the apparent correlation of one or more of these factors with vitamin C,⁹ are perhaps prophetic of future clinical applications of his terminology.

P. O. Box 51.

W. H. MANWARING.
Stanford University.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

ABORTION: INEVITABLE AND INCOMPLETE*

A STUDY OF 500 CASES

JAMES W. RAVENSCROFT, M. D.
San Diego

A DISCUSSION of this subject is appropriate for these reasons:

1. Abortions are common.
2. Women die from abortions.
3. Treatment is controversial.

Abortions are not rare. They occur rather frequently in the practice of every general practitioner, as well as in that of the obstetrician, and our hospitals are seldom without them.

Dr. Taussig¹ has stated that 20 per cent to 25 per cent of pregnancies terminate in abortion. It is the greatest single factor in maternal and fetal mortality, and approximately 40 per cent of maternal deaths are due to abortion.

This presentation deals with the clinical management of incomplete and inevitable abortions. The charts of 500 consecutive cases in the San Diego County Hospital from January, 1937 to June, 1941, have been personally analyzed in an attempt to ascertain the results and the important factors of treatment. Complete abortions, therapeutic abortions, and missed abortions have been excluded from this study.

DIAGNOSIS

Correct treatment first necessitates correct diagnosis. The vast majority of these cases consulted medical care because of one or more of the following reasons:

1. Vaginal bleeding, usually associated with passage of clots.
2. Lower abdominal pain, often of crampy nature.
3. Passage of decidual tissue or a fetus.
4. Evidence of infection, such as general malaise, foul lochia, tenderness of abdomen, or chills and fever.

The above signs and symptoms, associated with a history of amenorrhea in a woman in the child-bearing age, usually make the diagnosis evident. However, as these signs and symptoms are also associated with a myriad of other disturbances of the female pelvis, it is not surprising that missed diagnoses do occur. Virginia Hamilton,² in 1941, reported 13 per cent missed diagnoses on admission in a series of 502 cases of abortion. It is not within the scope of this paper to discuss differential diagnoses, but I do want to call to your attention that, occasionally, cases of pelvic in-

flammatory disease, hydatidiform mole, ectopic pregnancies, uterine polyps, ovarian cysts, fibroids, and malignancy of the cervix and corpus, masquerade as incomplete abortions. In the first 8 or 10 weeks of pregnancy the differential diagnosis is sometimes especially difficult, and it often requires a diagnostic curettage, with study of microscopic sections, to ascertain the correct diagnosis.

HISTORY

Granted a correct diagnosis, one is especially interested in ascertaining if instrumentation has occurred. This study shows that 90 cases, or 18 per cent of the patients admitted criminal interference. Some 70 per cent of such criminal abortions ran an infected course, while only 30 per cent of noncriminal cases were infected. This is important, because it is infection that accounts for most maternal mortalities in abortion. The history of previous criminal abortion is important. The author was impressed with the fact that too many women habitually have criminal abortions, until they almost die from severe infection. Also, many women deny criminal interference on admission, to confess it later in the hospital stay. It is also important to learn how many times the uterus has been invaded, as cases of repeated invasion run a more stormy course. The date of invasion is significant. If evidence of clinical infection does not manifest itself within one week, it is not likely to so do. The history of previous gonorrhea and pelvic inflammatory disease should be noted. If such history of recent infection is obtainable, the author believes that a course of sulfanilamide or sulfathiazole is justifiable before curettage, if such operative procedure is needed. Criminal abortion by medical means only does not increase the incidence of infection. The history of chills and fever classify the case as septic.

GENERAL EXAMINATION

The general appearance of the patient, the pulse rate, temperature, blood pressure, presence of jaundice, and evidence of tenderness, spasticity, or rigidity in the abdomen are very significant.

PELVIC EXAMINATION

The author has seen written on the admission record of charts, "Infected abortion; pelvic examinations deferred." Some physicians have advised that, in such cases, pelvic examination should not be done, because of the danger of spreading the infection. However, it seems to me that such procedure, done under sterile conditions, with good light and, above all, with gentleness, is invaluable, and often beneficial. Tenderness on motion of the cervix means parametritis, and that the infection has already spread beyond the limit of the uterus. This is an aid in prognosis, because it is this type of case that is most dangerous, causes the highest mortality

* Read before the Section on Obstetrics and Gynecology, at the Seventy-first Annual Session, of the California Medical Association, Del Monte, May 3-6, 1942.

rate, and which should not be curetted until infection is under control. In addition, most cases bleed freely, or go on to hemorrhage, due to decidual tissue in the cervix or lower uterine segment. In such cases the amount of bleeding can be appreciably decreased by removal of such tissue, often without anesthesia, by ovum or sponge forceps, even in the presence of infection. In most cases, such loosened decidual tissue blocks drainage from the cervix and favors the increase of infection. It is at times possible to complete abortion by this method of sponge forceps removal, or at least to establish good drainage. In 71 cases of the 500, such a procedure was done with good results. However, repeated pelvic examinations by several members of a hospital staff are to be condemned. Pelvic examination should not be abused.

LABORATORY AIDS

The presence of leucocytoses, with a shift to the left of polys, is indicative of infection. However, the white blood count is only an aid in diagnosis, and a normal count certainly should not be construed as meaning no infection. Each of the two patients in this study which died, and each of which was severely infected on admission, had respective white blood counts of only 8,050, with 73 per cent polys, and 11,700 with 86 per cent polys. The red blood count and hemoglobin determination, taken on admission, generally give a good idea of the degree of blood loss. Blood-typing should be done on all cases which may need transfusion. Neither sedimentation rates, nor cervical cultures were taken in these cases.

PERIOD OF OBSERVATION

Almost everyone agrees that active bleeding or hemorrhage demands evacuation of the contents of the uterus, even in the presence of infection. Forty-eight cases, or roughly 10 per cent in this series, had surgery within the first 24 hours after hospitalization, because of bleeding. As previously stated, most cases bleed because of decidual tissue in the cervix or uterus, which can often be removed with sponge forceps, sometimes without anesthesia. This procedure is less likely to spread infection than curettage, in infected cases. The author agrees that it is generally better to observe the patient 48 hours before surgery, if bleeding is not excessive, for the following reasons:

1. Infection may manifest itself during this time, which was not evident before.
2. A few patients will admit criminal abortion who denied it on admission.
3. Some cases will completely abort, especially cases of inevitable abortion on admission, and surgery will not be needed.
4. The period of absolute bed rest, high fluid intake, etc., improves most patients.
5. Patients who are in need of blood can be transfused.

6. The cervix in many patients further dilates, softens, and effaces, so that subsequent removal of the products of conception is easier.

At the end of 48 hours' observation, the attendant should be able to decide whether or not the abortion is complete; and he should also be able to decide an even more important factor, namely, whether or not the case is infected, and, if so, the degree of spread of the said infection.

TREATMENT

As stated previously, what constitutes proper treatment is controversial. I have just returned from the American Congress of Obstetrics and Gynecology, held in St. Louis, where I heard two interesting discussions of the proper treatment.

Dr. T. K. Brown, of St. Louis, who has written considerably on the subject, advocated active treatment; that is, intervention of the uterus in every patient, whether clean or infected, regardless of the degree of spread of said infection.

He³ empties the uterine cavity of débris under morphine-scopolamin semimarcoses, by a Foerster's sponge forceps and with, what he terms, a uterine wiper. He then gives a low pressure, 1-1000 KMNO₄ douche, at 110 to 115 degrees Fahrenheit.

Dr. James Reinberger, of Memphis, Tennessee, exemplified the other extreme; namely, medical treatment, and claimed that 97 per cent of his cases were cured by oxytoxics, blood transfusion, and sulfonimides. It⁴ was necessary to curette in only 3 per cent of his cases.

I feel that Dr. Brown's régime is too radical; such intervention is sometimes dangerous. We simply have been unable to empty the uterus in 97 per cent of cases, as Dr. Reinberger did, by use of medical treatment alone. However, the author believes in a "middle-of-the-road" course between these two types of treatment, and recommends a procedure as follows:

After 48 hours' observation, in noninfected, incomplete abortion, the evacuation of the uterus by dull curettage or sponge forceps. This removes decidual tissue and blood clots, which offer a fertile culture media for growth of bacteria. After the uterus is emptied, it contracts well, diminishing blood loss and aiding drainage.

In infected cases he advises a more conservative course. Any tissue blocking drainage should be removed from the cervix. The patient should be kept at absolute bed rest, given an adequate amount of fluids, and oxytoxics, such as small doses of pituitrin and ergonovine. Blood transfusions should be given, if needed, either to restore blood loss, or to increase resistance. Sulfanilamide or sulfathiazole is invaluable. The uterus can be emptied with either sponge forceps or by dull curettage, after the patient is fever-free for 3 to 4 days. The following charts show the method of treatment, with the number of hospital days, of the cases in this series. Thirty per cent were treated medically, 26 per cent treated with

sponge forceps; curettage was done in 44 per cent of the cases.

An analysis of cases is presented in Tables 1, 2, and 3.

TABLE 1.—Incidence of Infection and Criminal Interference

	Criminal	Noncriminal	Total
Infected	64	113	177
Noninfected	26	297	323

TABLE 2.—Method of Treatment of Cases

	Infected	Noninfected	Total
Medical	64	87	151 cases (30%)
Sponge Forceps ..	50	82	132 cases (26%)
Curette	63	154	217 cases (44%)
Total	177	323	500 cases (100%)

TABLE 3.—Hospital Days in Relation to Method of Treatment

	Infected	Noninfected
Medical	8.4 days	6 days
Sponge Forceps ..	9.8 days	6.6 days
Curette	8.1 days	5.9 days

In 15 cases receiving conservative care only, the patient had to return for subsequent curettage; and in 3 cases the patient returned for curettage, after sponge forceps only. In 6 cases a second curettage was needed.

FLARE-UP AFTER SURGICAL TREATMENT

Every patient who received either sponge forceps or curettage, and who had a fever of 101 degrees following surgery, excluding the day of surgery, was restudied. In 25 cases, or 7 per cent of surgically-treated patients, such a flare-up occurred. Nine of these cases had sponge forceps, and 16 had curettage. However, only 5 of the 25 cases having postoperative reaction had had sulfonimides before surgery. All of these patients recovered. Half of the cases which flared up were subjected to surgery in less than 24 hours after admission. However, it should be noted that it is not unusual for such flare-ups of fever to occur immediately after spontaneous passage of placental tissue or fetus. In such cases the temperature usually subsides within 2 to 3 days.

BLOOD TRANSFUSIONS

Blood transfusions were used in 112 cases, and some patients were transfused as many as 5 times. Whole blood is very valuable, as it not only restores blood loss, but increases the resistance of the patient to overcome her infection.

SULFONIMIDES

Either sulfathiazole or sulfanilamide was used in 118 of the 177 infected cases. The author believes that the administration of these drugs is invaluable in such infected cases. Cases receiving such treatment should, of course, have a re-check white blood count to determine developing leucopenia. The drugs should be stopped upon the appearance of severe toxic manifestations. Occasionally their administration causes a

fever which confuses the attendant. Of the two patients, which died, one received sulfanilamide for only 3 days, starting on the 5th hospital day; and the other received a total of 15 injections of Prontosil. Both these patients were extremely septic, and the drugs did not influence the patients' down-hill course.

REPORT OF CASES

CASE 1.—E. K., a white married female, age 28, Para. 11 Gr. IV, complained of general malaise, nausea, and vomiting, and vaginal bleeding 24 hours prior to admission. She passed clots, but no known tissue prior to admission. Denied criminal abortion. On admission, the uterus was enlarged, boggy and tender, and there were parametritis, spasticity of the lower abdomen, and jaundice. Laboratory Work: Icterus index 22; red blood count 1,720,000; hemoglobin 35 per cent; white blood count 11,700; with 86 per cent polys. The patient passed a small piece of tissue on admission, which showed inflammatory exudate, and necrotic tissue which could not be identified. The patient ran a temperature of 99 degrees to 101 degrees, and in spite of four blood transfusions, developed progressive weakness, vomiting, abdominal distention, foul lochia, and cyanosis. Sulfanilamide was administered for 3 days prior to death, which occurred on the 8th hospital day.

♦ ♦ ♦

CASE 2.—L. R., a 21-year-old married woman, para 0, Gr. 1, pregnant 4 months. Criminal abortion by abortionist. Had fever of 104 degrees, chills, rigid abdomen, and sepsis prior to admission. History of gonorrhea, with removal of right tubo-ovarian mass, a few months previously. Patient had sponge forceps removal of products of conception on 2nd hospital day. This was done without anesthesia, and cervix was widely dilated. About 5 gm. of placental tissue, removed, showed necrosis. Red blood count 3,874,000; hemoglobin 64 per cent; white blood count 8,050, with 73 per cent polys. Three blood cultures positive for staphylococcus aureus. Patient ran a temperature of 103 to 105 degrees, and had chills in the hospital. Death occurred, on the 9th hospital day, of peritonitis, sepsis and bronchopneumonia. Prontosil was given from the 3rd to 6th hospital days, a total of 75 c.c., without benefit.

CONCLUSIONS

1. Five hundred cases of incomplete or inevitable abortions were studied.
2. Ninety cases, or 18 per cent, admitted criminal interference.
3. Seventy per cent of criminal cases ran an infected course, while only 30 per cent of non-criminal cases were infected.
4. Two patients, severely infected on admission, died—a mortality of 0.4 per cent.
5. The author advises:
 - a. A complete history and examination on admission, including a sterile pelvic examination.
 - b. Speculum examination and removal of loosened decidua tissue from the cervix on admission, to establish surgical drainage, and to decrease blood loss.
 - c. A 48-hour observation period, unless bleeding demands intervention.
 - d. Early evacuation of noninfected, incomplete cases, with sponge forceps or dull curette.

- e. Conservative treatment with oxytoxics of infected incomplete cases until the temperature is normal for 3 to 4 days, before surgical intervention.
- f. Generous use of blood transfusions.
- g. Administration of sulfanilamide or sulfathiazole to infected cases, especially before surgical intervention.

1003 Medico-Dental Building.

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FOREIGN BODY LOCALIZATION BY X-RAY*

EARL R. MILLER, M.D.

San Francisco

THE purpose of this paper is to review methods of foreign-body localization by x-ray that can be used by the civilian radiologist in his own office or hospital on standard equipment. It is necessary that civilian radiologists become familiar with at least one simple rapid fluoroscopic method by which foreign bodies can be localized, because we all are going to be confronted with the necessity of helping the surgeon find and remove these bodies from civilians if a continental bombing should occur; or from evacuees from the Far Eastern scene, when they are returned for base hospital care.

If there is no hurry, films taken at right angles through a part, shown to contain a foreign body by fluoroscopic survey, is still an excellent method of localization. One not only demonstrates the type, number, and shape of the foreign particles, but one has a record of their position relative to anatomical structures, and a record of other injuries such as fractures.

However, if the number of patients is great, there will not be time for this method. Fluoroscopic localization will have to be relied upon. It is the only method acceptable to the army in emergency stations.

Time does not permit even a hasty review of the many papers written on this subject. Reid and Black, in *Radiology*, in November, 1938, listed and discussed 147 papers on foreign-body localization and added a new method. Since that time several other methods have been described. Major de Lorimer, in *Radiology*, April, 1941, de-

scribed the method used by the Army. For those interested, these papers are recommended for survey.

PROCEDURES

For your own office, however, you will find some difficulty in applying the described methods, unless you are willing to change the design of your machine. But several things can be done to help this situation.

The requirements are that the number, type, shape and position of foreign bodies be stated concisely. The position is usually given as the depth of a particle beneath a mark on the skin directly over the foreign body, or a mark is placed on the skin over the foreign body and its depth marked on the side of the patient.

Subcutaneous foreign bodies can be localized rather simply if one will make a metal-tipped exploring rod and determine the movability of foreign bodies by pressure on the skin over them. If such are found, their position should then be marked, and they should be labeled as subcutaneous.

For *localization of deep foreign bodies*, parallax can be used. To demonstrate the method, make a V (for victory) of the index and middle fingers of your left hand. Hold the hand about a foot from your face, so you look through the V. Put the tip of your right index finger half-way between your eye and the top of the V. Now, move your head from side to side. The index finger seems to move relative to the V. Now put the tip of your right index finger directly between the tips of the V, and move your head from side to side. Now the three fingers do not move relative to each other. The metal-tipped rod can be used beside the patient at the level of the foreign body as a parallax indicator. The screen and tube are moved back and forth. When the foreign body and the rod tip move the same amount, regardless of the tube shift, they are at the same level. In practice, a mark is placed on the skin over the image of the foreign body as seen through a very small shutter-opening, and a mark is placed on the side of the patient at the position of the rod tip. (See page 226, Army Manual.) There are special devices described, using the parallax principle. Some have rather elaborate, but simply-used scales to help determine the position of the foreign body in centimeters or inches from the front and back surfaces of the body, as well as marking its depth on the side of the patient. See Fig. 1.

DESCRIPTION OF APPARATUS

To simplify the explanation of the following methods, we will name a few parts of the apparatus. See Fig. 2. The rod connecting the tube carriage with the upright to the fluoroscopic screen is called the tube-carriage rod. A hand operated screw clamp which, when tightened, holds the tube and screen immovable relative to the table, is called the tube clamp.

* Read before the Section on Radiology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.
From the University of California Hospital.

A short, thick-walled tube, drilled to fit the tube carriage rod, and tapped to admit a small wing screw to tighten it to the rod, is called a rod-marker. This rod-marker is very handy. It need not be used in any of the methods, but it makes all of them easier to work. One can use a wax pencil to mark the position of the tube carriage rod relative to the rod clamp for marking the position of the tube relative to the table.

The Army uses a double tube shift triangulation method. Major de Lorimer's article gives a concise and graphic description of the method. However, it probably cannot be used as described on your own standard machine, because a focal screen distance of 66 centimeters is required. A method using this principle can be applied, however, if your tube and screen move together, if your screen is parallel to the table top, if you can determine the distance from your screen to the skin, and if there is a fixed target-screen distance or an easily-reproducible target-screen distance.

Most standard fluoroscopic tables allow about a 7-inch crossways shift of the tube and screen, and operate conveniently at a 24-inch target-screen distance. Choose a distance of crossways shift of the tube which is near the maximum and an even number of inches. For instance, if the tube will shift 7 inches, choose 6 inches as a working distance. Adjust the position of the screen so that the target-screen distance is 4 times the chosen crosswise shift. (In the above case, that would be $6 \times 4 = 24$ inches.) Fit a piece of cleared film to the frame of the fluoroscopic screen. Put a cross at the center of the image when the screen is lighted through a very small shutter opening. Put a cross on the right and left sides of the center cross at equal distances from it, so that the distance between the outside crosses is equal to the chosen crosswise shift of the tube. (In the above case, one would put a cross 3 inches on either side of the center cross.)



Fig. 102. Ruled celluloid sheet to indicate equality of displacement of two shadows in Method B.

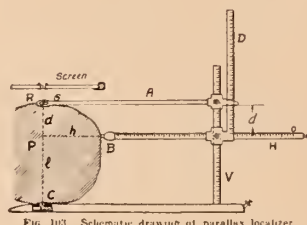


Fig. 103. Schematic drawing of parallax localizer.

Fig. 1.—(From U. S. Army Manual.) When B and P move the same amount while the screen is shifted from side to side, the two are at the same level. From this sort of a scale one can read d and h directly.

Locate the foreign body by fluoroscopic survey with the patient in the anatomical position. Close the shutter to a small opening and put a mark on the skin directly over the image of a point on the foreign body, as seen through this very small shutter opening.

Make the image of the foreign body coincide with the right hand cross. Mark the tube carriage rod at the place where it comes out from the side of the table with a pencil. Make the image of the foreign body coincide with the left-hand cross, and again mark the tube carriage rod as before. Measure the distance between the two marks. (Suppose this is $4\frac{3}{4}$ inches.) The difference between this measurement and the distance between the outside crosses (i.e., $6 - 4\frac{3}{4} = 1\frac{1}{4}$) is one-fourth of the distance from the screen to the foreign body, (i.e., $1\frac{1}{4} \times 4 = 5$ inches from screen to foreign body.) Subtract the screen-skin distance. This gives the depth of the foreign body beneath the mark on the skin.

Fig. 2.—Foreign-body localizer used at the University of California. This is a view of the apparatus, with the fluoroscopic table top removed.

W is the wire. C is the tube clamp. T is the tube-carriage rod. R is the rod-marker.



Fig. 3.—The detail picture below shows a close-up of the rod-marker.

You will find that marking the skin over the foreign body, and determining the screen-skin distance are difficult unless special apparatus is used.

DEPTH OF FOREIGN BODY

The next method allows one to read the depth of the foreign body on a scale on the fluoroscopic screen. It can be done in complete darkness, but the scale is so small (8 to 1) that large errors are possible.

Set the screen so that the tube-screen distance is 24 inches. Put a piece of cleared film over the screen, so that it will just fit the frame of the screen. Light the fluoroscopic screen through a very small shutter-opening. Put a cross on the

cleared film at the exact center of the lighted portion of the screen. To the left of this put a cross exactly 3 inches from the center cross. On the line of the centers of the crosses, and to the left of them mark off $\frac{1}{8}$ inch intervals, and number them consecutively from 0 at the left cross. Each $\frac{1}{8}$ inch represents 1 inch.

Locate the foreign body by fluoroscopic survey and move the screen so that the image of the foreign body coincides with the center cross. Mark the skin over the foreign body. Move the tube to the right exactly 3 inches. The image of the foreign body falls on the scale, giving its distance from the screen directly in inches. Subtract the screen-skin distance.

The simplest way to move the tube exactly 3 inches is to cut a piece of tongue-blade exactly 3 inches long. After the foreign body is centered to the center cross, fasten the rod marker tight against the tube clamp. Move the tube over until the 3-inch piece of tongue blade fits snugly between the rod marker and the tube clamp. Clamp the tube. Read the depth of the foreign body on the scale.

PROCEDURE AT U. C. HOSPITAL

The system used at the University of California obviates the necessity of having a fixed target-screen distance, and of determining the skin-screen distance. It does necessitate taping an opaque marker on the skin over the image of the foreign body.

Place a lead number (0) on the table top. Pile wood or magazines on top of it to a height of exactly 8 inches. Place another number (7) on top of the magazines and adjust its position so that the point of the 7 lies directly over the center of the 0 as seen fluoroscopically through a small shutter-opening. The screen must be parallel to the table top at any distance above it. On the tube carriage above the shutters place a straight, stiff wire near the edge of widest possible beam (a wire taped to a tongue blade works well). Move the tube and screen sideways until the image of the wire cuts through the center of the 0. Mark the position of the tube carriage rod relative to the side of the table. Now move the screen more sidewise in the same direction until the image of the wire passes through the point of the 7. Mark this position of the tube carriage rod relative to the side of the table. This will turn out to be nearly 2 inches. Now readjust the position of the wire until the distance between the two marks on the tube rail is exactly 2 inches when the above described maneuver is carried out. Once this position is found, fix the wire in this position. This should require not more than 2 or 3 minutes. The magazines and lead numbers are then removed and never need be used again. See Fig. 2 and Fig. 3.

To localize a foreign body in the tissues, find its image on the screen, and take a BB shot or any other small opaque marker directly over it on the skin. Move the screen sidewise until the image of the foreign body and the wire coincide.

Mark the tube carriage rail at the side of the table, or move the rod-marker against the tube clamp. Move the screen until the image of the wire coincides with the image of the skin marker. Mark the tube carriage rail at the side of the table or tighten the tube clamp. Measure the distance between the two marks or between the rod-marker and tube clamp and multiply by 4. This gives the distance between the skin marker and the foreign body. Actually a small 4-to-1 scale may be attached to the rod-marker as is shown in the figure. This system has the advantage that skin-screen distance does not need enter the calculations, and that the screen can be close to the table top for thin parts and far away for thick parts. The wire and the rod-marker do not interfere with regular fluoroscopy.

SUMMARY

The principles of the parallax double-tube shift and a parallelogram method of foreign body localization by x-ray are described.

Simple ways of applying these methods to the civilian radiologists' machines are outlined.

University of California Hospital.

CARCINOMA OF THE FALLOPIAN TUBE*

THEODORE S. KIMBALL, M. D.

HAROLD E. SANFORD, M. D.

AND

ALBERT F. BROWN, M. D.

Glendale

MALIGNANT tumors of certain organs of major surgical importance are so overshadowed by the much greater frequency of inflammatory disease in these sites that a diagnosis of the malignancy in an early local stage is practically never made preoperatively. Further, the enlargement and adherence produced by the two disease processes are so similar that the presence of a tumor is often not suspected even during the removal of the organ, and the discovery is left for the pathologist's routine examination.

Carcinoma of the Fallopian tube presents an outstanding example of this problem. It is rare in comparison with chronic salpingitis, and, when it does occur, it often resembles closely the inflammatory disease.

The most recent compilation³ gives the upper limit of incidence of this lesion in gynecological operations as 0.5 per cent, and the total number of reported cases as about 375. Additional recent reports^{2, 4, 5, 6} have added a few to this number. One author estimates the frequency as one in 1,000 salpingectomies.⁵

Age, in half the patients, is between 40 and 50, with the remainder between 18 and 80. The typical pathological description¹ is that of a club-

* Read before the Section on Pathology and Bacteriology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

From the Kimball Clinical Laboratory, and the Department of Pathology of the College of Medical Evangelists.

shaped adherent tube resembling an old pyosalpinx. The tumor is usually papillary and arises in the lateral half, sealing the fimbriated end but leaving the uterine ostium open. Fluid of inflammatory or degenerative origin distends the lumen, and escapes at intervals into the uterine cavity, giving rise to the phenomenon of "Hydrops tubae profluens." This is characterized by a profuse watery or blood-stained ("Hemohydrops") vaginal discharge, which follows and appears to relieve pain in the region of the tube. This symptom, correlated with negative findings on uterine curettement, is said to enable a correct preoperative diagnosis to be made, or at least suggested—a feat which has been accomplished only once or twice in all the reported cases. The prognosis is poor, not only because of lack of recognition and consequent nonradical removal of the tumor, but because of the thin-walled structure of the tube, ready access to lymphatics, and a tendency to occur bilaterally. Five-year cure is said to be obtained in less than 4 per cent. The value of roentgen irradiation has not been proven. Of the following case reports, the first two are from the Physicians' and Surgeons' Hospital of Glendale, and the third from the Glendale Sanitarium and Hospital.

REPORT OF CASES

CASE 1.—A white woman, age 49, was first seen May 11, 1936. She complained of severe abdominal cramps and excessive vaginal bleeding. She had had one pregnancy, with a normal delivery. For 16 years she had noted dull pain in the lower abdomen, and menorrhagia. Examination revealed good nutrition, apparent anemia; and in the lower abdomen, an irregular hard tumor extending to the umbilicus. Vaginal examination indicated this to be a uterus enlarged by multiple fibroid tumors. The hemoglobin was 50 per cent (Sahli), red-blood cell count 4.1 million. Other findings were normal.



Fig. 1.—Case 3. Left Fallopian tube. Posterior view. Lateral portion cut open to show the papillary tumor in the lumen. Enlarged $1\frac{1}{2}$ times.

On May 12, 1936, laparotomy (H.E.S.) disclosed a large fibromyomatous uterus. One Fallopian tube was moderately enlarged and thickened throughout. The other tube and both ovaries appeared normal. The uterus was

removed supracervically with the tubes. The patient recovered from the operation uneventfully.

Pathology. (T.S.K.) The uterus shows nothing of significance except the large multiple fibromyomata. One of the tubes is 7 cm. long, 2 cm. in diameter. Half of



Fig. 2.—Case 3. Carcinoma of Fallopian tube. $\times 475$, showing the deep invasive margin of the tumor. In this area there is marked anaplasia, with loss of gland structure.

this tube is very firm in consistency, and the lumen is filled with firm white tissue grossly appearing to be tumor. The other half of the tube is filled with gelatinous fluid. The other tube shows some distention of the lumen and flattening of the mucosal folds, but no evidence of tumor.

Microscopic. Sections of the Fallopian tube show an infiltrating growth of irregular glandular epithelium having a marked tendency to be thrown into folds, suggesting the probability that the tumor is primary in the tube itself.

Diagnosis. (1) Multiple fibromyomata of the uterus; (2) Fibroid polyp of the uterus; (3) Adenocarcinoma of the Fallopian tube.

Further course. Upon dismissal from the hospital the patient was advised to submit to radiation therapy, but she refused, and was not heard from again until Nov. 11, 1937. She was then found to have apparent cervical lymph node metastasis, and ascites. Laparotomy, necessitated by apparent intestinal obstruction, revealed peritoneal carcinomatosis, and the patient died Dec. 25, 1937, 19 months after the original operation.

CASE 2.—A white woman, age 54, had complained recently of abdominal pain, and a feeling of pressure in the pelvic region, made worse by standing. Examination

was negative, except for a mass palpable in the right lower quadrant. The hemoglobin was 79 per cent (Sahli), red-blood cell count 4 million.

Operation by Dr. H. G. Westphal, Dec. 11, 1936, revealed a large mass involving the right tube and ovary. Some excess abdominal fluid was noted. Both tubes and ovaries were removed, also the appendix.

Pathology. (T.S.K.) Specimen consists of a small tube and ovary, an appendix, and a large cystic mass having the gross appearance of a greatly dilated Fallopian tube with a large cyst of the ovary. The proximal end of the tube is of small diameter, but the remaining portion measures from 3 to 5 cm. in diameter, and has a rough, irregular external appearance. Sections through the tube at various places show the lumen to be almost completely filled with a papillary type of tumor which extends from near the proximal end for a distance of 9 cm. along the tube, at which point the lumen becomes larger and filled with a large mass of necrotic material which grossly resembles fibrin and decolorized blood clot. There is no evidence of tumor growth within this large cystic cavity, and the tumor is definitely limited to the Fallopian tube. The other tube reveals no evidence of tumor growth.

Microscopic. Sections of the Fallopian tube, at two different levels, show the lumen to be almost completely filled with a rather highly malignant-appearing tumor, having a distinct papillary arrangement suggesting the tube as the primary source. Many mitotic figures are present, and there is a poor attempt at gland formation.

Diagnosis. Carcinoma of the Fallopian tube, tubo-ovarian cyst, incidental appendix.

Further course. Dr. Westphal reported that the patient developed ascites and an apparent pelvic carcinomatosis. She died about a year and a half after the operation.

CASE 3.—The patient, a white woman of 37, consulted a physician in 1939, because of vaginal discharge. This consisted of a clear pink fluid which appeared during the three days preceding each period. There was considerable pelvic discomfort during this time. After each period there was also a discharge of brown fluid, lasting several days. The past history included a partial oophorectomy incidental to appendectomy in 1919; and an abortion, the only pregnancy, in 1925.

The discharge ceased, after curettement and symptoms were relieved, until February, 1941, when an apparent acute attack of pelvic inflammatory disease occurred. This subsided under medical treatment, but symptoms, such as backache and dysmenorrhea, remained. The periods of dysmenorrhea were followed by serous drainage from the vagina.

Operation for chronic pelvic inflammatory disease was done December, 1941, by Dr. B. P. Mundall. The left tube was enlarged in its lateral portion, resembling an old pyosalpinx, and adherent to the sigmoid colon and left ovary. The left ovary appeared otherwise normal. The right tube was moderately thickened and adherent, and the right ovary contained small cysts. Supracervical hysterectomy, bilateral salpingectomy, and partial resection of the right ovary were done.

Recovery from the operation was uneventful.

Pathology. The material, from the curettement in 1939, showed a small benign endometrial polyp and fragments of normal follicular endometrium.

The specimens from the recent operation show a normal-sized uterus with slightly hyperplastic but smooth and thin-layered endometrium. The tubes show moderate chronic salpingitis. In addition, the lateral third of the left tube is enlarged to a diameter of 2.5 cm., and the dilated lumen in this portion is filled with a friable papillary growth. This does not involve the outer sur-

face. The lateral ostium is partially sealed and was probably completely closed before separation of the adhesions. The medial portion of the tube is patent. No evidence of tumor is found, grossly, or microscopically, elsewhere in the specimens. The fragment from the right ovary shows chronic inflammatory change only.

Microscopic. Sections of the tubal growth show an epithelial tumor invading the wall rather shallowly and projecting into the lumen as a papillary mass. The deeper portions of the tumor are partially alveolar and partially solid in structure. The cells are fairly uniform, but large and dark-staining, with moderately numerous mitotic figures. Groups of the tumor cells are found in the lumen of a small vessel near the outer edge of the wall.

Diagnosis. (1) Uterus without lesion; (2) Papillary adenocarcinoma of Fallopian tube; (3) Chronic oöphoritis.

COMMENT

The histories of these patients illustrate the difficulty of diagnosis, both before and during surgery. In the first case the clinical picture was dominated by the large uterine fibromyomata; in the second case, the tumor apparently failed to produce a tubo-uterine discharge; and in the third case the pain and discharge cycle, though present, was not entirely typical. In all three instances, the changes observed in the tubes at the time of surgery were not distinguishable from those of chronic inflammatory disease.

Two of the patients succumbed in less than two years after the discovery of the malignancy. The postoperative period in the third case has been too brief to allow any conclusions, but the tumor seemed grossly much less extensive than in the other cases. This patient may, therefore, be expected to survive considerably longer, though hope of a complete cure is somewhat depressed by the microscopic evidence of intravascular growth of the tumor cells.†

A study of these and other reported cases suggests that the prognosis might often have been somewhat improved by an immediate opening of all significantly enlarged tubes and inspection of the contents. Recognition of the tumor could then be followed by appropriately radical excision.

318 N. Central, Glendale.
3806 Ocean View, Montrose.
312 N. Boyle Ave., Los Angeles.

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†The patient has now had a second operation, ten months later, revealing a recurrence of the tumor in the pelvis.

CONTACT STOMATITIS DUE TO A DENTURE IN A METAL SENSITIVE PATIENT

KARL J. DEISSLER, M.D.

Oakland

AND

G. RUTLEDGE SHEETS, D.D.S.

Oakland

A CASE of contact stomatitis in a metal sensitive patient (nickel-cobalt), was found to be due to the nickel content of a denture made of a dental casting alloy, "Ticonium." Contact stomatitis, due to dentures consisting of synthetic material (hecolite), has been described by Rattner.¹ The following studies and observations appear to be of interest.

REPORT OF CASE

The patient is a married, white woman, forty-three years old. Her general history is irrelevant. No allergic manifestations such as pollinosis, asthma or eczema had been observed among any of her relatives. She stated that, approximately three years ago, she had acquired an upper partial dental plate, but she had been unable to wear it because it caused the following disturbances in her mouth:

A few hours after it was put in place, the patient noticed slightly increased salivation; and after approximately twelve hours, a burning and itching sensation. If the denture was removed, after twelve to fourteen hours, these disturbances would disappear in a few hours, except for a slight redness in the area of contact of the denture and the mucosa.

If the denture was left in the mouth for approximately twenty-four hours, the mucosa became inflamed and finally ulcerated, leaving a denuded area approximately two millimeters in depth, with elevated edges. An inflammatory edema involved the whole mouth, particularly the soft palate. The itching and burning increased, until it became practically unbearable. If the denture was not replaced, the lesion disappeared gradually and completely.

The plate was recast to insure a better fit, as it was assumed that the lesions were due to pressure against an unusually sensitive mucosa. However, the patient was unable to tolerate the new denture.

COMMENT

At this time, one of us (Dr. G. Rutledge Sheets), covered the denture with Eugenol paste and instructed the patient to wear the plate. The patient was able to wear the plate without symptoms for a period of time, in which symptoms had always developed on previous trial. A part of the Eugenol was removed, the metal exposed, and a lesion developed in the mouth exactly corresponding to the area of contact. Contact stomatitis due to the denture was assumed.

After the problem was discussed with the patient, she produced, at a subsequent visit, three items, namely, a ring, part of a wrist watch and a necklace. She stated that she had worn the ring for several months when she developed, on the area of contact of the ring and her fingers, an itching skin lesion which returned every time she again wore the ring for two or three days.

The alloy, of which the denture was made, proved to be Ticonium, the constituents of which are (according to the manufacturer), nickel, cobalt, chromium, molybdenum and beryllium.

FURTHER TESTS

Nickel sensitivity was suspected, and the following patch tests were carried out: The denture itself, a strip of Ticonium, a strip of dental gold and a buffalo nickel were cleaned with acetic acid, and applied to the skin of the upper arm so that they remained in close contact.

After forty-eight hours, typically positive patch tests had developed under the denture, the strip of Ticonium and the buffalo nickel. The skin under the strip of dental gold showed no change. After twelve hours the itching had become very marked.

On two successive occasions these tests were repeated in combination with nickel sulfate solution, 5 per cent. On each successive trial the patch test reactions occurred and were comparatively more severe. The nickel solution elicited a typical positive patch test.

Contact with a small piece of nickel produced a characteristic lesion on the patient's palate after ten hours.

Passive transfer tests with the patient's serum, in which the sensitized areas were patch tested with nickel, gave negative results.

A nickel-free casting material was found in the commercial product, "Vitalium." A preliminary patch test gave, to our surprise, a positive reaction. According to the manufacturer, Vitalium consists of cobalt, 65 per cent; chromium, 30 per cent, and molybdenum, 5 per cent.

Patch tests with the following solutions gave these reactions: chromium potassium sulphate 10 per cent aqueous, negative; cobalt chloride 2 per cent aqueous, positive; molybdenum, not done.

CONCLUSION

It was concluded: 1—that the patient was nickel- and cobalt-sensitive; 2—that her oral lesions represented a contact stomatitis.

The etiology and pathology of this contact stomatitis were thought to be the same as that of her skin lesions, which were of the nature of a contact dermatitis in a nickel-sensitive patient.

The alloy used for her denture was a widely used, commercially available alloy: Ticonium.

DISCUSSION

The initial sensitization was thought to be due to the nickel-containing ring. It was worn at first without symptoms for at least two months. During that period a local and general sensitivity to nickel developed. Contact with nickel in the same ring, in a wrist watch and a necklace produced skin lesions, and the time of these occurrences (after ten hours of contact), suggests that at that time the sensitivity had been well established. ("Beschleunigte Reaktion.")

Extensive exposure to nickel during patch-testing further intensified and sped up the reaction of the patient.

Nickel-containing alloys are frequently used in dentistry as casting alloys for dentures. They remain in prolonged and intimate contact with

body tissues under conditions which favor their solution in liquid media and their absorption.

It is to be expected that patients already sensitized to nickel, or those who become sensitized while wearing their dentures, will develop a contact stomatitis. Among cases of nickel sensitivity nickel contact dermatitis is a comparatively frequent form of clinical nickel sensitivity. It is not infrequently seen in patients whose history gives no suggestion of heavy or prolonged exposure, and it is to be assumed that these patients become exceptionally readily sensitized due to some undetermined predisposing factor.

It is suggested that nickel sensitivity be suspected in patients who wear metal dentures, and who develop local or general stomatitis, if no other explanation can be found for their stomatitis.

A careful history and the simple procedure of patch-testing the patient with the material to be used in the denture will reveal an already existing nickel sensitivity, and save the patient and the dentist much inconvenience. However, a previously normal patient may become sensitized while wearing the dentures, and in such a case patch-testing may or may not be helpful, depending on whether or not the sensitization has become generalized.

The medico-legal aspect is to be remembered, as the patient might claim negligence on the part of the dentist. The dentist certainly would not want to be less careful regarding his methods than the operator in a beauty salon, in which a patch test is an established routine before an application of a skin-sensitizing hair dye.

Finally, attention is called to the possibility of metal sensitivity or metal sensitization, its potentially grave sequelae and the necessity for patch testing, in the use of alloys in orthopedic surgery, where such alloys remain in prolonged and close contact with human tissue when they are used in bone surgery, as plate screws, nails and lag screws. Attention should be paid to metal sensitivities in complications after the use of alloys in bone surgery, and it is suggested that the irritating qualities of such alloys may be due, in an occasional case, to sensitivity to one or more of the metallic constituents.

SUMMARY

A case of contact stomatitis due to nickel sensitivity in a metal (nickel, cobalt), sensitive patient is described. The significance of metal sensitivity in dentistry and orthopedic surgery is discussed.

357 Thirtieth Street
426 Seventeenth Street

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Germes were first seen by man in 1676 when Anthony Leeuwenhoek made a one-lens microscope.

Loss of only 20 per cent of the body's water content causes death.

TOXEMIAS OF LATE PREGNANCY: OUTLINES OF THERAPY*

ERNEST W. PAGE, M. D.

Berkeley

THE presentation of a system of therapy for the hypertensive disorders of pregnancy in tabular and outline form has an advantage in its simplicity and readiness for use. The summary below has been prepared primarily for the physician who is only occasionally confronted with such toxemias, and who has not the time for studying the innumerable articles on the subject. Much of the current literature bearing on the treatment of toxemias is concerned with specific aspects of treatment, often based upon some favored theory as to etiology; or it discusses the treatment of eclampsia in such general terms, with so many alternate methods of therapy, that practical directions are difficult to obtain. An outline such as this, on the other hand, is quite inadequate for the specialist who is interested primarily in the academic arguments relating to therapy. Many of the reasons for accepting or rejecting a procedure or a drug, and the references pertaining thereto, are sacrifices to brevity.

Until the exact etiology of the hypertensive syndromes is known, the treatment must remain symptomatic. We have learned much about the pathologic physiology of eclampsia, and this information is our only basis for any rational therapy. The methods outlined below have been modified gradually over a period of years, and are derived from many sources. They are quite identical with those now in use at both the Alameda County Hospital and the Los Angeles County Hospital.

CLASSIFICATION AND INCIDENCE

Hypertension, as a symptom, appears in three to ten per cent of pregnancies, the actual incidence depending upon the type of sample selected for study. The classification of that hypertension is important to the patient only insofar as it determines the prognosis and treatment. Several classifications have been devised, and four of these are presented in Table 1.

It will be noted that, in all classifications, there are two major divisions: the "pure" or specific toxemia peculiar to pregnancy and the various preëxistent vascular or renal diseases complicated by pregnancy. Occasionally there are mixed types, the former being superimposed upon the latter; but this should not deter us from attempting an exact diagnosis. The frequency distribution of the different groups is also shown in the table, and in the last column these percentages have been determined for both a hospital and a private series. The hospital cases show a much higher incidence of hypertensive complications simply

* Read before Section on Obstetrics and Gynecology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

because those patients were referred in for treatment, but the types of cases observed are otherwise similar.

There is very strong evidence that arteriolar and glomerular damage may persist after pre-eclampsia or eclampsia, especially when the toxemia was of long duration. When these women become pregnant again they may, in late pregnancy, present a syndrome quite like that of essential hypertension, though differing in several details. This syndrome I have labeled "post-eclampsism toxemias." The remaining groups are too well known to need definition.

DIFFERENTIAL DIAGNOSIS

Using the classification in the last column, the major points of differential diagnosis are presented in Table 2, the most important points for differentiating these syndromes being underlined.

any way with the development of toxemias. The higher incidence of severe toxemias (and deaths) in women who do not have prenatal care is due for the most part to the failure in starting them on a therapeutic régime early enough to interrupt the progress of the disease.

Outline of treatment follows:

I. PREECLAMPSIA

Method of Grading Severity:

It is quite important to grade the seriousness of pre-eclamptic toxemia before instituting treatment. Individual estimates vary widely, and the following objective method has proven to be of considerable value.

(a) Add systolic and diastolic pressures, and subtract 230 (i.e., the sum of 140/90).

(b) To this figure add 10 for each "plus." or each gram of albumin up to 40 points.

TABLE 1.—Classifications of Toxemias of Late Pregnancy

American Committee on Maternal Welfare	Stander (90) cases	Dieckmann (1100 cases)	A* (280 cases) 8.3%	B* (56) 3%
Preeclampsia	Low reserve kidney	Preeclampsia	Preeclampsia, 63%	64%
Mild	68%	47%	Mild, 111	27
Severe	Preeclampsia		Moderate, 48	9
	9%		Severe, 17	0
Eclampsia	Eclampsia	Eclampsia	Eclampsia, 8.6%	10%
Convulsive	4%	4.4%	Mild, 17	6
Nonconvulsive			Severe, 7	0
			(3 deaths)	
Hypertensive Disease				
a. Benign		Essential	Essential	
1. Mild		hypertension	hypertension, 10.8%	10%
2. Severe		12%		
b. Malignant	Chronic Nephritis		"Posteclampsism	
	19%		Toxemias", 14.4%	10%
Renal Disease				
a. Chronic vascular		Vascular-renal		
nephritis		disease		
b. Glomerulonephritis		36%	Chronic glomerulo-	
c. Nephrosis			nephritis, 3.2%	2%
d. Other forms				
Unclassified				
(Cases excluded because	10	572	40	1
of incomplete data or in-				
decision)				

*Series A represents the distribution of 280 consecutive cases of hypertension in pregnancy during one year at the Los Angeles County Hospital. Series B represents 56 consecutive private cases of Dr. Clarence W. Page during a ten-year period. In all columns, the unclassified cases were excluded before calculating the frequent percentage.

PROPHYLAXIS

In vascular, or renal diseases, existing prior to pregnancy, the only available prophylaxis is the prevention of pregnancy, or its early interruption in severe cases.

The only proven prophylaxis of eclampsia is the early detection and prompt treatment of pre-eclampsia. The mild grades of pre-eclampsia appear in spite of rigid observance, especially in short, pyknic overweight women with evidences of endocrine disturbances. The only measure of probable value is the strict control of the sodium and water balance during the last trimester of pregnancy in those women showing edema or rapid weight gain. True weight gain (as represented by the body-weight on the tenth postpartum day, minus the body-weight at the beginning of pregnancy), is probably not correlated in

(c) List the symptoms for the past 24 hours and add the following points, depending on your estimate of their severity.

Headache	10, 15 or 20
Visual disturbances	5, 10 or 15
Edema (hands or face)	5 or 10
Nausea and vomiting	5 or 10
Epigastric pain with liver tenderness, or jaundice	25 or 50

The sum constitutes the "toxemia index." An index below 20 is negligible; 20-50 = mild; 50-100 = moderate, and over 100 = dangerously severe. This system is applicable only to pre-eclampsia and, while seemingly complicated, has proven (over the last seven years), to be of prognostic value. Daily tabulations will give an accurate indication of progress.

A. Treatment of Mild Grades:

1. Single room. Blood pressure twice daily. Daily qualitative albumin determination on voided morning specimen. No blood chemistry necessary.
2. Fluids—1500 to 2000 c.c. in 24 hours. Chart intake and output.
3. Salt-poor (i.e., less than 3 gms.), soft diet. No baking soda.
4. Phenobarbital, gr. $\frac{1}{2}$ or 1 t.i.d.
5. Milk of magnesia each night, sufficient to maintain free elimination. Antepartum cases, if in the hospital, may be discharged 24 hours after symptoms of toxemia have subsided, though treatment should continue. *Patients showing no improvement after 48 hours should be treated as of moderate grade severity.*

ride (preferably enteric coated), 4 to 6 grams (e.g., gr. xxx t.i.d. p.c.), for three to five days.

(Comment: This acts as a diuretic, and the ammonium ion is converted to urea, leaving the chloride ion to take up sodium from the sodium acid carbonate in the blood. The sodium chloride is excreted in the urine.)

6. Mild saline catharsis.

7. If systolic blood pressure should exceed 170, or diastolic exceed 115, give 20 c.c. of 10 per cent magnesium sulphate intravenously (very slowly), and repeat in 2 to 4 hours if necessary.

8. *Ordinarily, labor should be induced if the severity is not lessened to a mild grade within 48 hours.*

TABLE 2.—Differential Diagnosis of Hypertension in Pregnancy

	Preëclampsia and Eclampsia	Essential Hypertension	"Posteclampsia toxemia"	Chronic Nephritis
<i>Parity</i>	Majority primiparae	Majority multiparae	Multiparae (by definition)	Majority multiparae
<i>Family History</i>	0	Significant	0	0
<i>History of Hypertension</i>	0	Usually	Only in late pregnancy	Often
<i>History of Nephritis</i>	0	0	0	Usually
<i>History of Eclampsia</i>	0	Recurrent "toxemias"	Always (by definition)	Recurrent "toxemias"
<i>Edema</i>	Usually	Rare	Rare	Slight
<i>Headaches</i>	Often constant and severe	Throbbing, mild, occipital	Rare	?
<i>Visual Disturbances</i>	Acute	Chronic and uncommon	Uncommon	Chronic
<i>Epigastric Pain</i>	In severe cases	0	0	0
<i>Convulsions</i>	In eclampsia (by definition)	Eclampsia occasionally superimposed. Otherwise, convulsions rare.		Only with uremia
<i>Onset of Symptoms</i>	3rd trimester	Before, or in first half of pregnancy	2nd half of pregnancy	Before or in 1st half. Abortion common
<i>"Personality Type"</i>	Average	"Hypertensive make-up"	Average	Average
<i>Eye grounds (severe cases)</i>	Edema and acute h. t. retinopathy	Chronic h. t. retinopathy	Usually mild	Chronic retinopathy
<i>Lability of B. P.</i>	Marked	Marked in early cases; not in late	Marked	Tends to be constant
<i>Cold Pressor Test</i>	Average (?)	Hyperreactive	Usually hyperreactive	?
<i>Albuminuria</i>	Mild to severe; acute	Absent or mild	Absent or mild	Chronic. (Also casts and r. b. c.)
<i>N. P. N. or Urea</i>	Usually normal	Normal	Normal	Elevated
<i>Blood Uric Acid</i>	Elevated in proportion to liver damage	Normal	Normal	Elevated only in proportion to other metabolites
<i>Concentrating Power of Kidney</i>	Usually normal	Normal except in severe types	Normal	Usually impaired
<i>B. P. on Following Examinations</i>	Normal	Elevated and progressive	Normal	Usually elevated

B. Moderate Grade of Severity:

1. Single room, and no visitors. Quantitative albumin determinations on morning urine specimens. Request blood N.P.N. and total serum proteins. Examine eye grounds.
2. Fluids—1500 to 2000 c.c./24 hours. Accurate record of intake and output.
3. Salt-poor, low fat, high carbohydrate and high protein diet. Give dextrose in lemon juice between meals.
4. Sufficient sedation to keep patient slightly drowsy.
5. If edema is present, give ammonium chlo-

C. Severe Grades:

Treatment is the same as that outlined below for eclampsia. *Pregnancy should be terminated by the most conservative means, if the severity is not lessened to a moderate grade within 24 hours.*

(Comment: In all toxemia cases, the patient may usually be returned to a normal régime by the fourth day postpartum, especially if active diuresis has occurred.)

II. ECLAMPSIA

Method of Grading Severity (Dieckmann):

The criterion for severe eclampsia is the presence of one or more of the following findings:

(a) Persistent coma; (b) temperature of 103 degrees or more; (c) pulse rate over 120; (d) respiratory rate over 40; (e) more than ten convulsions; (f) cardiovascular impairment, as evidence by pulmonary edema, persistent cyanosis, low or falling blood pressure, or weak pulse; and (g) the failure of medical treatment to stop convulsions, or to produce a diuresis of at least 700 c.c./24 hours or to overcome coma.

General Management of Patient:

1. Absolute rest in a darkened room, with sideboards on the bed and a constant attendant. Minimum handling of patient. Do not disturb with enemas, lavages or repeated manipulations. Leave B.P. cuff on arm. Turn patient on her side if she is in coma. Protect tongue from injury (but do not try to force tongue blades between teeth after a convulsion has started). Have a bulb at hand for aspirating mucus from throat.

2. Use oxygen tent if available; if not, give inhalations of oxygen during, and for five minutes after each convulsion.

Procedures:

3. Take B.P. hourly (or oftener), during acute phase; later, every three hours, if systolic pressure is over 150; otherwise twice daily. In antepartum cases check fetal heart tones each time blood pressure is taken.

4. Daily quantitative albumin determination until fourth day postpartum. Microscopic examination of catheterized specimen shortly after entry.

5. Chart intake and output daily. Physician is to be notified if output falls below 500 c.c./24 hours.

6. Type for transfusion (for use in the event of hemorrhage or shock).

7. Request the following blood chemistry: N.P.N., serum proteins, uric acid, and CO₂ combining power.

8. Examine evegrounds (but not during acute phase, for sudden light may precipitate a convulsion).

9. Obtain a consultation on cases of eclampsia for your own protection.

Diet and Fluids:

10. Nothing by mouth except water until eight hours after convulsions have ceased; then order a soft, highcarbohydrate, high protein, neutral or acid ash and low salt diet.

11. Give between 1500-2000 c.c. fluids in 24 hours. (This includes parenteral fluids.)

12. If total proteins are below 5.0, or if diuresis fails to occur within a reasonable time, give a plasma or serum transfusion.

(*Comment:* Remarkably good results may be obtained even though the serum proteins are not elevated by the transfusion.)

Medications:

13. Give 20 c.c. of 10 per cent magnesium sulphate on entry, after each convulsion, or when systolic pressure exceeds 150; but do not give

more often than once an hour, nor more than eight injections in one day. Test knee-jerks before each injection, and, if absent, do not give magnesium sulphate. If anuria is present, do not give more than one injection.

(*Comment:* The therapeutic results of intravenous magnesium sulphate depend upon attaining sufficient blood concentration to relax arteriolar construction. Excretion is entirely through the kidneys; so that severe oliguria may result in cumulative effects. Calcium is an immediate antidote for medullary depression. Since calcium likewise relaxes arterioles, infusions of a combined magnesium lactate and calcium lactate solution are being tried experimentally.)

14. On entry, give 200 or 250 c.c. of 25 per cent dextrose in distilled water (not in saline or Ringer's solution). Give three or four times daily during acute phase of toxemia.

15. If convulsions do not cease following intravenous magnesium sulphate, give (a) 8 to 12 c.c. of paraldehyde by deep intramuscular injection (or 15 to 30 c.c. rectally), or use (b) sodium phenobarbital gr. v (or sodium amytal gr. v) intramuscularly, repeating in 8-12 hours if necessary. Do not use opiates or intravenous barbiturates.

16. Give mild saline cathartics for free elimination.

Treatment of Complications:

1. *Acute pulmonary edema.*—Fowler's position, tracheal suction, oxygen, digoxin or digitanid intravenously. Inflate cuffs on three extremities to 110 mm., or remove 300-500 c.c. blood.

2. *Acute vascular collapse.*—(Systolic B.P. below 90). Trendelenberg position; caffeine or ephedrine; start 5 per cent glucose in distilled water and follow as soon as possible with blood or plasma.

3. *Anuria.*—Give 50 c.c. of 50 per cent dextrose intravenously. (Give slowly and avoid leakage.) Repeat as indicated.

Obstetrical Management:

In antepartum cases, as soon as the patient improves or becomes stationary (ordinarily within 15 hours after treatment is started), labor should be induced, usually by rupture of membranes. If the patient is less than eight months' pregnant, or if there is cephalopelvic disproportion, a cesarean section under local or cyclopropane anesthesia may be the most conservative means of delivery. Cesarean section, however, is not done for eclampsia alone. Do not use pituitrin (because of its pressor and antidiuretic fractions). If necessary, use pitocin.

UNDESIRABLE METHODS

Other drugs and procedures used in the treatment of eclampsia are almost too numerous to mention. Certain ones, such as purging, colonic lavage, sweating, and routine ureteral drainage, are meddlesome. Nitrites, thiocyanates and mercurial diuretics have been tried and found to be dangerous. *Veratrum viride* is still used in a few

places, but is a powerful cardiac depressant and has been discarded by most authorities. Spinal drainage does not relieve true cerebral edema and may damage medullary centers by downward expansion of the brain. All sodium salts in appreciable amounts are contraindicated. Forcing fluids during the acute stages of toxemia is dangerous, and extreme dehydration reduces the urinary output and may result in the prerenal accumulation of metabolites. Ether and chloroform may add insult to a damaged liver. Opiates in average doses do not control eclamptic convulsions, and in large doses actually increase the spinal reflexes and depress the respiratory center. The endocrine therapy of preëclampsia and eclampsia is in a highly unsettled and experimental stage, and the use of hormones in this disease is not at present on any rational basis.

III. ESSENTIAL HYPERTENSION, POSTECLAMPSISM TOXEMIAS AND CHRONIC GLOMERULONEPHRITIS

In all three of these diseases, the treatment is similar and is essentially the same as the accepted medical management outside of pregnancy: for example: rest, continuous mild sedation, salt-poor diet, and in the presence of renal insufficiency, low protein intake. Pregnancy *per se* does not create an added excretory load for the kidneys, as commonly believed. Women with preëxisting renal or vascular diseases, however, are more likely to develop a superimposed preëclampsia, in which case the treatment is like that outlined above. The first indication of this is usually a sudden increase in albuminuria and edema. Women with essential hypertension have an even chance of going through pregnancy without an exacerbation. The most important consideration in each of these three syndromes is the decision as to when to terminate pregnancy. The rare case of malignant hypertension, or of chronic glomerulonephritis with renal insufficiency, should have a therapeutic abortion. Late in pregnancy, any hypertension which shows a steady increase and is accompanied by any degree of albuminuria will, in a very few weeks, cause irreversible vascular damage. This fact must be borne in mind in considering the time for inducing labor.

IN CONCLUSION

Questions involving the etiology of eclampsia, or any other of these hypertensive disorders of pregnancy, have been purposely avoided. Until we learn the basic causes, mothers will continue to die from these complications, and until we learn those causes, there can be no specific therapy. Our treatment must remain on a physiologically, rational, symptomatic basis.

2560 Bancroft Way.

Man's intellectual and spiritual destiny is in no small degree determined by what and how he reads. As reading is a mark of civilized peoples, so is it of individuals who grow and progress. Its importance, which arose with the art of writing, mounted rapidly after the invention of printing, and reached its present climax through the wide diffusion of books.—Leon J. Richardson.

MEDICAL EPONYM

Argyll Robertson Pupil

Although he credits Stellwag von Carion with the statement that tabes dorsalis and spinal paralysis may cause paralytic myosis, the account of the rigid pupil in his report, entitled "On an Interesting Series of Eye-symptoms in a Case of Spinal Disease, with Remarks on the Action of Belladonna on the Iris, etc.," in the *Edinburgh Medical Journal* (14:696-708, 1869), together with a later report, "Four Cases of Spinal Myosis; with Remarks on the Action of Light on the Pupil," in the same journal (15:487-493, 1869), has served to affix permanently the name of Douglas Argyll Robertson (1873-1908), lecturer on diseases of the eye at the University of Edinburgh, to this phenomenon. The following quotation is from the earlier article:

"On examining the eyes, I found both pupils contracted to little more than pin-points, the right rather the smaller of the two. . . . I could not observe any contraction of either pupil under the influence of light, but, on accommodating the eyes for a near object, both pupils contracted."—R. W. B., in *New England Journal of Medicine*.

'Chutist Tells How It Feels to Fall 5½ Miles in Two Minutes.—Two impression packed minutes in which Arthur H. Starnes, veteran stunt flyer, fell five and a half miles before opening his parachute were described tonight. Starnes did not lose consciousness. He felt no physical effects.

The Northwestern University Medical School tonight made a full report on the delayed jump in which Starnes stepped out of a plane 31,400 feet in the stratosphere loaded with equipment which measured his heartbeat, the speed of his fall, body spins and effects of atmospheric pressure.

For 29,300 feet Starnes tumbled through the air in a free fall that lasted 116.5 seconds. At 2,000 feet he pulled the rip cord on his parachute and took another two minutes to float leisurely to the ground.

A log of Starnes' tumble read like this:

31,400 feet—Stepped from plane flying 171 miles per hour. Fall began at rate of 43 miles per hour with a horizontal movement caused by the speed of the plane.

30,200 feet—Now falling 199 miles an hour downward.

28,850 feet—Had fallen almost half a mile. Time elapsed, 19.1 seconds. Slight body spin, spin cut fall to 170 miles per hour. . . .

23,200 feet—Passed through cloud. Goggles frosted outside.

21,750 feet—Kicking out of spin and staying belly down to present maximum body surface to increasing atmospheric pressure cut fall to 179 miles an hour; 42.1 seconds gone. . . .

3,170 feet—Speed 188 m.p.h. Pulled up frosted goggle to look at altimeter to determine when pull rip cord. Glanced at ground, realized in flat spin. Sensation dizziness. Transiently nauseated.

2,100 feet—Pulled rip cord.

Starnes said that he at no time felt like he was hanging in midair. The veteran jumper made five other test jumps from lesser heights for the four physicians conducting the experiments—Dr. Andrew C. Ivy, Dr. Louis R. Krasno and Dr. Albert H. Andrews of Northwestern University, and Dr. Anton J. Carlson of the University of Chicago.

He wore a special oxygen mask and an electrically heated suit. A short wave radio broadcast his heart beat to a recording disc on the ground below.—*San Francisco Chronicle*, December 11.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals: For Colleagues in Military Service

In former issues appeared editorial comment on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Post-graduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

If you have not read the editorial outline of the plan in the September issue, you are urged to do so.

Medical journals and books may be sent to any of the addresses listed below:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," collect, to: C.M.A. Post-graduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261).

I

The Pepper Hearings on Medical Manpower

The Procurement and Assignment Service for Physicians, Dentists and Veterinarians, established as a part of the War Manpower Commission, is carrying on a scientific, carefully considered allocation of physicians, dentists and veterinarians to meet the needs of the armed forces, industry and the civilian population, as directed by the President of the United States in his order establishing this body. Nevertheless, a small group of individuals, including a few physicians, apparently dissatisfied with actions of the Procurement and Assignment Service in some instances, was mustered to appear before a subcommittee of the Committee on Education and

† Harold A. Fletcher, M.D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M.D., 1930 Wilshire Boulevard, Los Angeles.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (DRexel 5241).

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone EXbrook 3386, Local 46.

For the southern section of the State, the Office of Naval Officer Procurement is in charge of Lt. Comdr. John P. Ewing, MC. The office is located at the Naval Armory, 850 Lilac Terrace, Los Angeles.

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

† For complete roster of officers, see advertising pages 2, 4, and 6.

Labor of the United States Senate for hearings now being held in Washington. The American Medical Association was represented only on its own request. Obviously the American press has not been able to reflect fully the various facets of what some newspaper men have described as a "one-man inquisition," conducted by Senator Pepper. *The Journal* hopes in future issues to print a rather full account of the hearings. Physicians may then judge for themselves the nature of the inquiry and the end apparently sought.

One of the chief facets thus far obvious is the desire of some industrial leaders and of the full time staffs of physicians which they employ to maintain their individual empires without disturbance regardless of the needs of the armed forces for physicians. They believe apparently that individual physicians should be taken by the armed forces before clinics, private hospital staffs, industrial organizations or similar groups are in any way disturbed. The first objective of the nation is the winning of the war. The armed forces require preferably physicians under 40 years of age. The decision as to who is physically fit or unfit for military service and as to who is "essential" or "not essential" cannot be left to the opinion of the individual physician himself or to the organization which employs him.

The statements of Dr. Frank H. Lahey, chairman of the board, and of Dr. Max E. Lapham, director of the Procurement and Assignment Service, placed clearly before the Pepper "inquisition" the facts regarding the number of physicians in the United States, their availability for various types of service, the procedures that are being followed in protecting industry and civilian communities against a shortage of medical manpower, and the absolute impartiality with which the affairs of the Procurement and Assignment Service are being administered. Some witnesses tried to force the concept that the personnel of the Procurement and Assignment Service with all its widespread organization throughout the nation, including the corps area boards and the state and county officials, all of whom contribute their services without remuneration, are creatures of the officials of the American Medical Association. Some representatives were charged with utilizing their positions to interfere seriously with the orderly functioning of American medical practice and indeed to injure the public health. The concept is itself as false as many of the other insinuations that were made by some of those who testified. This will be clear to every physician who studies this testimony when it is printed.

Prime movers in this assault on the Procurement and Assignment Service and perhaps also on the War Manpower Commission, of which it is a part, are, as will be obvious from the testimony, Paul de Kruif, Ph.D., Michael M. Davis, Ph.D., Mr. Henry J. Kaiser, eminent industrialist, the head of his medical services, Dr. Sidney Garfield, and two physicians who are said to have been heard in executive sessions of the committee and whose names are thus far not available. Accompanying Senator Pepper in his conduct of the "inquisition" are two economists, most of whose questions, as will also be clear in the published testimony, are directed toward establishing the view that American medicine has failed to meet its obligations in the war effort and that some agency must be established with totalitarian control over all medical facilities.

In his testimony before the hearings, Dr. Thomas Parran, of the U. S. Public Health Service, spoke strongly in behalf of the services being given by the medical profession in this time of the nation's need and stated without the slightest equivocation:

SENATOR PEPPER: Do you think that allocation of med-

ical personnel between military services and civilian work should have been handled through the Public Health Service rather than through the Procurement and Assignment Service?

DR. PARRAN: I think the present arrangement is the best. As a matter of fact, after seeing the system as it was set up in Great Britain eighteen months ago, I discussed that system with the Health and Medical Committee and others and perhaps was responsible to some extent for a separate group representing the medical and dental professions being set up to deal with this problem.

Nevertheless, "Ph.D.s" de Kruif and Davis do not hesitate to endeavor to force on the U. S. Public Health Service a responsibility which the Surgeon General of that service certainly does not seek and which is opposed to his own statement based on serious study and established knowledge, that he considers the present method "best."

Already evidence has been submitted that the services established by Mr. Henry J. Kaiser, under the direction of Dr. Sidney Garfield, are endeavoring to hold from the armed forces even the opportunity to determine for themselves whether or not the considerable number of young men employed on salaries by this industrial organization are fit and available for military service. Certainly the decision as to whether or not these young men may best serve the nation in time of war in the armed forces or in the civilian capacities which they now occupy cannot be left to their employers. The final responsibility does not rest on the Procurement and Assignment Service, which can only indicate its belief as to whether or not such men are essential. The decision rests—and wisely—with the local boards in the areas concerned; these boards may give consideration to the recommendations made by the Procurement and Assignment Service. From the decisions of the local Selective Service boards appeal may be made, according to conditions established by our government, even as high as the national agencies in Washington or the President himself. Every young physician in the United States under 40 years of age should now determine in his own heart and in the light of the principles of public service traditional in medicine, whether or not he is doing his utmost to serve the nation in this time of emergency.

When the transcript of the hearings is published in forthcoming issues of the *The Journal*, readers may determine the extent to which the hearings conducted by Senator Claude Pepper of Florida represent a courteous effort on the part of a public official to determine the facts, so that representatives of the people may legislate wisely to meet the needs of the hour, or whether or not a public agency, namely a senatorial hearing, is being used—or abused—under the leadership of a senator, to pillory a profession. Already that profession has contributed to the armed forces more than forty thousand physicians, the very best that the nation can supply. The remainder are working without thought of hours, of exposure, of fatigue or of recompense to maintain medical service for the American people in this time of trial. The performance displayed in Senator Pepper's hearings is not likely to improve the morale of American medicine at the very time when it should be at its highest in the service of the war effort.—Editorial in *Journ. A.M.A.*, Nov. 14, 1942.

* * *

II

The Pepper Hearings on Medical Manpower

Immediately following the editorials in this issue of *The Journal* [November 21, pp. 927-966], appears the report of the hearings before the Pepper Subcommittee on Education and Labor dealing with medical manpower.

A preliminary editorial on the subject was published in *The Journal* last week. Almost simultaneously with these hearings appeared an editorial in the *New York Times*, a public statement by Michael M. Davis, a press release by the so-called New York Physicians' Forum, a group of some one hundred and thirty physicians in New York City. This group includes among its leaders Drs. Ernst P. Boas and Miles Atkinson. Physicians will remember the recent appearance of these two physicians on a forum held in Washington and their insistence on a revolution in the nature of medical practice. Even before the United States entered the war, the prediction was made by many physicians that attempts would occur to utilize the emergency as an excuse for radical changes in the administration of medical services in this country.

In the report of the hearings which follows, attention is called particularly to certain highlights which merit special consideration. Dr. Frank H. Lahey placed before the committee the present status of the Procurement and Assignment Service and indicated some of the difficulties involved in the work which it is conducting. Senator Hill was exceedingly courteous to Dr. Lahey, although somewhat later in the hearings Senator Pepper intimated that Dr. Lahey is merely an automaton or marionette functioning at the behest of the Army and Navy. This will no doubt surprise Dr. Lahey.

Dr. Thomas Parran attempted to state the exact situation as he observed it. Both the Senator and his economist advisers seemed to be much annoyed that Dr. Parran did not adopt the words which they endeavored to put into his mouth.

Paul de Kruif, Ph.D. in bacteriology, indicated that he had not made any personal investigation of the Procurement and Assignment Service or of its work and that he was speaking largely from hearsay. He did draw into the situation the case of Dr. Tom Spies. Immediately following the publicity accorded to this incident, the editor of *The Journal* called Dr. Spies on the telephone. According to what Dr. Spies reported, it was the belief of a friend and preceptor that Dr. Spies should be in military service; apparently this friend asked de Kruif to speak to Dr. Spies on the subject. This was the widely publicized incident which de Kruif characterized by saying that the American Medical Association had "put the finger" on Dr. Spies. The evidence indicates that de Kruif is dissatisfied with the American Medical Association or those whom he characterizes as its leaders, although the specific cause of his annoyance is not made clear.

Mr. Henry J. Kaiser and the director of his medical services, Dr. Sidney Garfield, claim to have had some difficulties with the local representatives of the Procurement and Assignment Service because of their desire to hold in their permanent organization young physicians who have been marked "available" by the Procurement and Assignment Service.

Senator Pepper did not permit the editor of *The Journal* to make any formal statement. The hearing was conducted wholly by the question and answer technique. This procedure Senator Pepper followed frequently with all who appeared, so that much of the hearing is devoted to long statements by Senator Pepper with the answer "Yes, sir" and "Certainly, sir" from those who were supporting the cause in which the hearings were held. The editor of *The Journal* apparently found it difficult to say "Yes, sir"; it will be observed that he frequently said "No, sir"...

Mr. Michael M. Davis, Ph.D., presumably in economics, spoke as was expected.

It will be interesting to see what kind of report the Subcommittee on Education and Labor makes to its full

committee. There is apparently an effort on the part of this senatorial group to set up an independent agency for the control of all manpower, with Mr. Henry Wallace, vice-president of the United States, as its head. Presumably they would take authority from the Selective Service System and from the present War Manpower Commission as now constituted and make all agencies subservient to what Senator Pepper calls an "over-all" committee.—Editorial in *Journ. A.M.A.*, Nov. 21, 1942.

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Excerpts from "Pepper Hearing" at Washington, D. C., November 2, 1942. (Reprinted from *Jour. A.M.A.*, issue of Nov. 21, 1942.)

Interrogation of Morris Fishbein, M. D.

SENATOR PEPPER: *What do you regard as the essential needs of the armed forces, how many doctors per thousand men?* DR. FISHBEIN: I say now that they are asking 6.5 men per thousand. But if they reduce that to what Great Britain has, 4.5 per thousand, there would still not be enough young doctors to meet their needs if young doctors, men under 37 years of age, take jobs in industry in order to avoid military service.

SENATOR PEPPER: *Are there any doctors in the armed service engaged in administrative work?* DR. FISHBEIN: By a joint directive from the Joint Army and Navy Board, both Army and Navy medical departments have been instructed to take from the desk every doctor capable of giving medical service in the field.

SENATOR PEPPER: *Well now, Doctor, suppose that you should find doctors occupying key places in industry, that is the maintenance of the health of the employees of companies that build ships and cannon and airplanes and the implements of war, then it would be the old question of determining which is more important, the man or the gun, wouldn't it?* DR. FISHBEIN: Senator Pepper, that question has been given the most careful consideration by groups of the leading industrial physicians in the United States, and I mean the industrial physicians for organizations as large as General Motors, du Pont, Chrysler and Ford. All these men who are the leading industrial physicians in the United States have sat on these boards, which are making the decisions as to what constitutes an essential physician in industry.

Considering this matter purely as a matter of general information, the kind of knowledge that any man can have, it is quite obvious that a man who has built up an industrial organization for a great industry of the scope of General Motors or du Pont, and who has all of his physicians of various grades and specialties rendering service, does not wish, in wartime, to see one man moved out of that job.

We didn't like the idea of taking what I would say were seven key men from the headquarters of the American Medical Association because we have to take in other men, older, and train them to fit jobs for which we have trained men for ten and fifteen years. But we made a decision very early that if the armed forces needed a man he was to go, and we would take an older man and train him in the job.

SENATOR PEPPER: *Now who knows more about the public health, the armed forces or competent people who have the responsibility for the maintenance of our industrial operations, and the people who are in direct touch with the public health?* DR. FISHBEIN: I would agree with you at once that the leading industrial physicians of the United States know much more about industrial medicine than I do, and these decisions have been made by the leading physicians in industrial medicine in this country.

SENATOR PEPPER: *You mean the decisions in a local draft board?* DR. FISHBEIN: I mean the decisions having to do with the standards which should determine whether or not a physician in industrial medicine was or was not an essential man in that position.

SENATOR PEPPER: *Well, now, the man who is the head of a particular medical unit would also have some very important knowledge on that subject, would he not?* DR. FISHBEIN: The man who is the head of that unit, this being a democracy, has open to him four or five different methods of approach for carrying his problem to the highest point, namely Washington. He can carry his problem to the national Selective Service System. When a draft board takes a man whom he considers essential, he is privileged to file an appeal; he can carry that to his appeal board; he can carry it from the appeal

board to the national Selective Service System. And specifically, if there are 11 doctors under 37 years of age employed in any hospital associated with an industry, and if a draft board takes any 1 of those 11 who are essential to that industry, the man in charge has two methods by which he can retain the man. The man can appeal and the industry can appeal on his behalf, that is through the draft board route. Now through the Procurement and Assignment route he can again appeal to the state procurement officer; from the state procurement officer he can appeal to the corps area procurement board; from the corps area procurement board to the national board of Procurement and Assignment, on which the final decision would rest. Now if no such appeal has come up on behalf of any man from the agency that wants to keep the man, the fault cannot rest with the agency at the top, it must rest with the man who failed to file the appeal.

SENATOR PEPPER: *You mean that that is one of the methods he may pursue. Can you tell us how many men regarded as essential to the maintenance of health facilities have been kept out of the clutches of Selective Service by any of the Procurement and Assignment officials?* DR. FISHBAIN: Many hundreds.

SENATOR PEPPER: *Give us your best estimate?* DR. FISHBAIN: I wouldn't like to give an estimate, but I will file a definite statement with you as soon as I investigate the matter.

SENATOR PEPPER: *All right, we will be glad to receive that.* DR. FISHBAIN: I would have to make a special investigation on that point, but I can have the information for you.

SENATOR PEPPER: *Now in the various counties I believe you said there were representatives of the Procurement and Assignment Service?* DR. FISHBAIN: In some, not in all. There are, for instance, eight counties in the United States with less than 5 people to a square mile. No one attempts to handle that situation by setting up an organization. In some two thousand counties there are probably men who would act for the Procurement and Assignment Service, or committees of men, in grading doctors as essential or as not essential.

SENATOR PEPPER: *Dr. Lamb has some questions.*

DR. LAMB: *In connection with your point of a moment ago, Doctor, essential physicians in industry such as you were describing are not limited to those employed specifically by the large industries; that is to say, the health of industrial workers depends very largely on the average individual physician in a given community, or a member of a hospital staff, or what not?* DR. FISHBAIN: Yes, sir.

DR. LAMB: *Appeals on individual cases in other parts of the Selective Service, which I think this committee has already determined are not well protected by the present occupational deferment machinery, are no substitute for the good working of a system in which the overall plan is adequate—you would agree with that?* DR. FISHBAIN: That is absolutely right.

DR. LAMB: *So that your statement of a moment ago that these deferments might be secured for individuals is not, in your estimation, any substitute for the adequacy of the plan?* DR. FISHBAIN: Oh no. To move on to that next step which you have just raised, I am convinced that there must be and will be—of course if this war lasts—an overall control over all professional and trained personnel. There must be, because in no field is there a sufficient number of men to meet the special needs created by an army of the size proposed.

DR. LAMB: *Right on that point, we have at the present time about 40,000 physicians, you said, in the armed services?* DR. FISHBAIN: Yes.

DR. LAMB: *And I take it from what you said that they are the great majority of those under 40?* DR. FISHBAIN: Yes, it is about half of those under 40. The average age of graduation is 28 years, and they graduate each year between 5,500 and 6,000 doctors. They take one year of internship before they are considered competent, and then if they care to go into a specialty they must take a residency. All that is being looked after, that is the maintenance of a minimum number of residents, and the maintenance of a minimum number of interns—that has all been given thought. In the twelve year period it would give you 72,000 doctors under 40, which is just about right.

DR. LAMB: *Now if we have seven and a half million man army, as stated by Secretary Stimson as the goal for 1943, that would mean that if all those who are serving in the armed service are in that category of under 40 you will have all of the doctors of that age; is that correct?* DR. FISHBAIN: Fortunately for us they are not all under 40 and the exact figures are available as to just how many are now in the armed forces and in the civilian population, under 40 and above 40.

DR. LAMB: *Would you give them to the committee?* DR. FISHBAIN: I will leave them with you. For every five year age group beginning with the first year of the medical school and upward, as high as they go, we have all the doctors of this country classified—

DR. LAMB: *Dr. Lahey testified that out of that 176,000 you would not classify more than 120,000 of them as effective physicians.*

DR. FISHBAIN: That is, effective for all purposes. Now we classify, for example, a bare 30 per cent of the men over 65 as effective for all purposes, and when you get over 70 that would drop still further. Under 35 years of age, 42,671 physicians; from 35 to 44, 41,558 physicians; from 45 years to 54, 31,399 physicians. Now that gives you, let us say, under 45 about 84,000 doctors, effective doctors, in the country, and they would be considered, let us say, effective for all purposes, the men under 45 years of age.

DR. LAMB: *What part of those are included in the 40,000 or more in the armed forces?* DR. FISHBAIN: I would say that the large majority of them are included in the 40,000, but you see there is a total there of 85,000 doctors, so there is still half of those left.

DR. LAMB: *In other words we have approximately 45,000 doctors, or less, now available and considered to be in their prime, for the service of 120,000,000 people?*

DR. FISHBAIN: Again that is not quite right for the simple reason that the age period from 45 to 55 gives you 32,000 doctors and from 55 to 65, 30,000 doctors. Now the effective age for the civilian population, perhaps the best age for the civilian population of the doctor is 55 to 65.

DR. LAMB: *If I may interrupt, you have now given us 143,000 doctors under 65, and a moment ago we were discussing the possibility that only 120,000 physicians in the country were effective, and that gives us at least 23,000 who are not in the effective class.* DR. FISHBAIN: If you want to class all of the officers of the United States Public Health Service as not in the effective class—

DR. LAMB (interposing): *We are concerned with their effectiveness for the purpose of caring for the civilian population and your figure of 1 to each 1,500 was based on that. . . .*

DR. LAMB: *Thank you. Will you state your corrections?* DR. FISHBAIN: You are assuming, in the first place, that the American Medical Association drew up plans for controlling the overall distribution of the medical profession in the United States, and they didn't.

DR. LAMB: *I am not assuming anything of the sort.* DR. FISHBAIN: It is in your question, if you will have the record read.

DR. LAMB: *I am assuming that originally the plans worked out for Procurement and Assignment are those which were worked out through the operations of your county by county and state by state estimating system. is that correct?* DR. FISHBAIN: They declared certain doctors available and certain doctors unavailable, but—

DR. LAMB (interposing): *And this is the framework under which Procurement and Assignment has gone on. What sort of protests has the American Medical Association made with respect to the continuation of enlistment of doctors?* DR. FISHBAIN: There have been letters that have gone forward to the Surgeon General of the Army and to the Secretary of War. As rapidly as it appeared that in certain areas the condition was becoming what would ordinarily be called tight, authorities representing the armed forces were informed of the fact that in certain areas of the country conditions were becoming tight and that some action should be taken. But that action had to be taken by federal agencies.

DR. LAMB: *But no effort was made to request that enlistments stop entirely and that some other system be substituted?* DR. FISHBAIN: The withdrawal of the recruiting teams was not a matter of a single action suddenly withdrawing all the recruiting teams. Just as soon as it was apparent that recruiting should stop in certain areas, it stopped in those areas, even by direct recommendation from the corps area commander, who, under our present system of Army control has the control, in his corps area, over the recruiting teams.

DR. LAMB: *Would you testify, Doctor, that in January of this year it was impossible for the American Medical Association to foresee the effects of enlistment?* DR. FISHBAIN: I think that they were clearly understood in January of this year by the Procurement and Assignment Service.

DR. LAMB: *Were there any representations by the American Medical Association to either the Surgeon General or the Procurement and Assignment Service, demanding that in January enlistments should be stopped of doctors and that some other system should be substituted therefor?* DR. FISHBAIN: We are not in the habit of demanding anything.

DR. LAMB: Were letters written along those lines? DR. FISHBAIN: Yes.

DR. LAMB: Will you furnish the committee with any letters to that effect written by the American Medical Association in January of this year? DR. FISHBAIN: I think it would be more in order for you to request either the Secretary of War or the Surgeon General of the Army to produce such correspondence than to ask us to produce our correspondence with them, and I think that the Surgeon General would tell you that that matter has been looked after.

DR. LAMB: Since this was a matter of initiative on your part it seems a correct request, but the committee, I am sure, will be glad to request that correspondence from these other sources. DR. FISHBAIN: I am quite willing to ask the permission of the Secretary of War to send you the correspondence we had with him, if you wish to have it. I don't know where these authorities lie.

DR. LAMB: I am sure that Senator Pepper would be glad to correspond with the Secretary of War to secure that correspondence. Now this question with respect to the ratio of 1 to 1,500; obviously that is an average and therefore has very little relationship to this 1 to 4,100 or 1 to 7,000, or whatnot? DR. FISHBAIN: On that I agree with you.

DR. LAMB: Yet it is your belief that quotas should be established for areas in which those ratios prevail and that further recruitment of physicians should be carried on through the Procurement and Assignment Board? DR. FISHBAIN: On the contrary, I have stated to the Procurement and Assignment Service repeatedly, and indeed as late as yesterday, that a quota based on an overall quota for a state like Alabama, where they have one large city with a concentration of doctors in it, and a large rural area without a concentration of doctors, that the setting up of an arbitrary quota for the state of 1 to 1,500 would produce an inequitable and intolerable situation.

DR. LAMB: You have so protested since last December repeatedly? DR. FISHBAIN: Yes, that is true.

DR. GARFIELD: May I ask you a question, Doctor? DR. FISHBAIN: Yes.

DR. GARFIELD: Why couldn't men over 40 take care of the base hospitals in a thousand or so army hospitals in this country? How many of the younger men are in active service? Are you aware of the fact that the Seventy-third Evacuation Unit has 40 of the best young surgeons in the country, it was formed in February, and from February until now they have been stationed in some small hospital in California doing nothing? DR. FISHBAIN: I am essentially a civilian doctor and I venture to state that if you were to ask the United States Army Medical Department about the necessity for physicians in the armed forces and how it is proposed that they will use them, that the United States Army will be able to tell you why physicians must be in training.

I am asked on behalf of a physician from Boston who is a well-known, competent ophthalmologist and who had enlisted in the Army, why that physician had been three months in a hospital and in a medical unit of the Army in Alabama without seeing any eye cases. But if the tank unit with which he had been associated was at that moment in Egypt he would be seeing more eye cases than he could possibly handle, and he must be trained with his unit. You can't train him in Boston to go with a tank unit when that unit starts out.

DR. GARFIELD: Do they train him in eye work, Doctor? DR. FISHBAIN: They train him primarily in the functions of a medical officer in the Army. As far as I know—and again I am no authority on military medical service—it becomes essential in operating the armed forces to train men with the units which they are to accompany. You can't train a man in one place and then order him to the unit when the unit goes into battle.

DR. GARFIELD: Isn't it true that there are forty base hospitals being built in this country, with innumerable army hospitals throughout the country, and couldn't doctors over 45 man those hospitals? DR. FISHBAIN: They not only could, but there are many, many doctors over 45 doing that. I have seen a urologist whom I know to be 57 years of age working in one of those hospitals. I have been in areas in Florida, in army areas, within the past year, where I have seen gynecologists operating on soldiers. Those gynecologists enlisted in the Army. They were men well over 45 years of age, and they were enlisted with the definite idea that they would be retained in this country.

But again if we must have young men with the Army, if we must have men under 37 years of age, or at least under 40 years of age, to meet modern condition of warfare, and if the needs of the Army in combat are to be met, some overall agency must be concerned with utilizing

the supply of young men and replacing them, as far as possible in civilian life and in the whole area, with older men. That is scientific handling of the men.

This is as good a time as any to correct a complete misstatement of fact. The policy has been adopted by the Procurement and Assignment Service, by the War Manpower Commission and, after adoption by them, approved by the American Medical Association, for the setting up of prepayment plans in all industrial areas where the needs of a rapidly growing industrial community demand that as the most efficient way of rendering medical service.

DR. LAMB: Doctor, when was that adopted? DR. FISHBAIN: That was adopted by the Procurement and Assignment Service Board at least three months ago; it was adopted by the Committee on War Participation of the American Medical Association about two and a half months ago; it was adopted by the Board of Trustees of the American Medical Association in the second week in September.

DR. LAMB: Has it yet reached the Procurement and Assignment local offices? DR. FISHBAIN: It was given out to the public and was given out to all agencies, as far as I know.

DR. LAMB: And they are already acting on that to the best of your knowledge? DR. FISHBAIN: To the best of my knowledge. Any one that wants to find it can have a copy of it. This is a large country and there are 120,000,000 civilians to be handled. In a service that embraces hundreds of thousands of people it is quite conceivable that some one man somewhere may not know everything that is going on. That is quite possible with respect to this man, whoever the person is, I haven't any idea with whom Dr. Garfield conferred on this matter.

DR. GARFIELD: Three states, California, Oregon and Washington. DR. FISHBAIN: If they will read the policy as it was adopted and has been published in *The Journal of the American Medical Association*, and released to the press and in other ways given out, the plan for meeting the civilian needs in relationship to medicine has been thoroughly discussed and carefully worked out and is already functioning in many places. I will give you if you want—I will put them in the record—the names of many areas which are already being supplied with doctors because they have a shortage of doctors, and these are being supplied by a voluntary system, by doctors who have volunteered to move to other areas, and some of them are going to such places.

MR. KAISER: Then I take it, Doctor, you believe in prepaid medicine? DR. FISHBAIN: I believe in prepaid medicine to such an extent that our own employees are insured under a hospitalization plan.

MR. KAISER: And you support it wholeheartedly? DR. FISHBAIN: I don't say all plans. I believe in prepayment plans that are set up on a legitimate basis; there are many strange plans set up on a peculiar basis.

MR. KAISER: We are assuming that they are legitimate: we wouldn't want anything that was illegitimate. The next thing is, if you were in my position and you couldn't get your men into a hospital and you were in an area, what would you do about it? DR. FISHBAIN: Well, it all depends. This question was asked me by another committee before which I testified recently—

MR. KAISER (interposing): This is a specific case, we have — men—DR. FISHBAIN (interposing): In the first place I believe always in operating within the law, whenever possible.

MR. KAISER: We are agreeable to that. DR. FISHBAIN: States have laws regulating medical practice so that it is impossible to bring a man into the state of Florida—and I mention Florida merely because that is one of the states that has the most rigid laws that exist in the country—

MR. KAISER (interposing): I would like to get back to where I was—you will get me lost. DR. FISHBAIN: Washington, Oregon and California.

MR. KAISER: Yes. Here is the question exactly. I would like to get back to it because you are carrying me all over the country and I will be lost. What would you do about my specific case? DR. FISHBAIN: If I were you I would ask my medical director to look into all the possibilities and not to try to solve the problem sitting where he is, but to go to the places where people have the information as to how the problem is to be solved.

SENATOR PEPPER: You mean to come to you, Doctor? DR. FISHBAIN: No sir, come to the federal agencies which are charged with this task, and that is the Procurement and Assignment Service in this case.

SENATOR PEPPER: That are being run by the American Medical Association? DR. FISHBAIN: Mr. Pepper, I would question that statement very strongly. If you can establish the fact—

SENATOR PEPPER (*interposing*): *Haven't you worked hand in glove with McNutt on this problem; you consulted with him on his speeches, didn't you?* DR. FISHBEIN: No, that is absolutely untrue. I have never seen—I can make this as a statement of fact, Senator Pepper—I have never seen in my life a speech of Mr. McNutt before it was written. I have published two of them after they were written.

DR. LAMB: *Dr. Fishbein, are you the chairman or director of information for Procurement and Assignment?* DR. FISHBEIN: I am Chairman of the Committee on Information. My purpose is to disseminate to the public—and this is the only function I have—through various press agencies and through medical periodicals the information which that agency wishes to send out.

Now, then, can you tell me any way in which the Procurement and Assignment Service could secure the co-operation and functioning of the medical profession without letting the doctors of the country know what their decisions were and how they function? Since obviously the publications which I edit, including medical and lay publications, are the best way of reaching the medical profession of the United States, the Procurement and Assignment Service would be operating inefficiently if it failed to utilize those legitimate means of publicity.

DR. LAMB: *And your services?* DR. FISHBEIN: Well, my services consist principally in this: When they send me a statement and say, "Please give this publicity," I publish it in *The Journal*. I send it to all the other medical journals of the country, and I send it to the press of the country. Now if anything can be found wrong with that procedure, anything out of the way, which indicates any control over their actions, I would like to have you point it out.

SENATOR PEPPER: *How often have you consulted with the Procurement and Assignment agency or Mr. McNutt?* DR. FISHBEIN: When they had matters of publicity to be given out they sent them to me by mail in 95 per cent of the cases. I have been present at one or two meetings where they wished me to be present in order that I might give out publicity. I do not sit with the board at their meetings.

SENATOR PEPPER: *Getting back to Mr. Kaiser's question as to what you would do in his case in trying to provide medical attention—* DR. FISHBEIN (*interposing*): I know that Mr. Kaiser personally is not going out to hire doctors, he is going to ask one of his subordinates to handle the matter; that is obviously Dr. Garfield. Now if Dr. Garfield had utilized methods which other men in the state of Washington were utilizing to get doctors to replace the younger men, he probably could have gotten them.

MR. KAISER: *I would like to make this point, and you will be glad to know this for your information, that in the Portland area we do have or did have that problem, but the doctors as a whole took hold of the problem themselves, organized all the hospitals and did render this service. We did nothing there, but that was not done in the other cities. Now what would you have where it was not done?* DR. FISHBEIN: What did Dr. Garfield do? Did he go beyond those people to any agency? As far as I know he has not taken the matter up directly with the national Procurement and Assignment office. Obviously if he had they are in a position to look into the picture. But I do not believe, personally, that they would be warranted in marking his young men "essential."

DR. GARFIELD: *We organized our medical service at Richmond before there was a Procurement and Assignment Service in the first place, and we chose people who we thought were ineligible for the Army as much as possible.* DR. FISHBEIN: But the Army thought differently?

DR. GARFIELD: *No, I beg your pardon, the Army now is reclassifying them.* DR. FISHBEIN: I mean the Army might think differently because they thought differently on a lot of things. The standards for the Army have changed greatly since December 7. We didn't take in men, before December 7, who had less than twelve teeth, so we had a 35 per cent rejection on account of teeth. Now we have got a 3 per cent rejection on account of teeth.

DR. GARFIELD: *We took men from all over the country, we got the best men we could. Now Procurement and Assignment says "You send all your men back to the Army and see if they want them," and that would break up our medical organization. There is one other thing. We had a shortage of beds in the area. Do you want us to go to the government and ask them for funds to build those hospitals?* DR. FISHBEIN: You have to ask them for materials, whether you ask them for funds or not.

MR. KAISER: *No, they don't give you the materials.*

DR. FISHBEIN: How do you get them?

MR. KAISER: *Priorities.*

DR. FISHBEIN: Do you know what the priority rating on hospitals is?

MR. KAISER: *It is A-1 when it comes to shipbuilding, because that is the only way you can get the doctors you are talking about, over there, by giving them a ship to go over in. I want you to get that clear.*

DR. FISHBEIN: I happen to know what Dr. Parran testified about concerning the building of hospitals. Now I know, and everybody knows, that in the new areas of industrial employment—

MR. KAISER (*interposing*): *You are getting away from my ship.*

DR. FISHBEIN: No, I am not. In new industrial areas such as those with which you are concerned, because obviously you didn't have all those people there before we got into the war, there are a total of about 5,000,000 people in the United States who have moved for an industrial job as the result of the war. Wherever they have gone we need hospitals, we need one at Valparaiso, Florida; we need them out in Richmond, probably; and we need them in Vancouver—but it is impossible to build a hospital using private funds or government funds now without obtaining a release on essential materials.

MR. KAISER: *We are doing it today, increasing our facilities.*

DR. FISHBEIN: I would say, Mr. Kaiser, that you are a very strong man and you get many things done that other men who are not quite so active do not get done.

MR. KAISER: *That is a beautiful out! But again how can we get the young man over to do the fighting unless he has something to sail in?*

DR. FISHBEIN: And how can you get him to sail unless you have a doctor with him?

MR. KAISER: *He therefore needs transportation and his health, and the health of the men that are building this transportation becomes fully as important as the men we send over.*

DR. FISHBEIN: Well, that is slightly debatable: whether or not a sailor or a marine who is fighting is more important than a shipbuilder, but I don't want to debate that.

MR. KAISER: *Please, I asked you a question and don't give the answer from me, I ask you to give it for yourself. Is it important to have transportation?* DR. FISHBEIN: It is of the utmost importance.

MR. KAISER: *And is it equally important to have the men there to build the transportation?* DR. FISHBEIN: It is important.

MR. KAISER: *Is it equally important?* DR. FISHBEIN: Equally important?

MR. KAISER: *Now the next question is: In that particular area where we didn't have that service, wouldn't you have created it?* DR. FISHBEIN: If I were there I would have had it.

MR. KAISER: *I really think you would do a remarkable work if you would immediately get busy, where it isn't being done today, and see that they are taken care of; and rather than defending it, correct it.* DR. FISHBEIN: Pardon me, I am not defending anything. I am trying to show you that your statements have been made, and also those of Dr. Garfield, without a knowledge of what has already been done and is being done. You are concerned only with your little problem.

MR. KAISER: *But it is only a model of them all, and I am now suggesting that you be concerned with them all and get this done.* DR. FISHBEIN: Suppose I told you that already we have reports from sixteen states in which there was said to be a shortage of doctors in certain areas that in ten of those states the shortages have been corrected. At Mobile, Alabama, the shortage has been corrected by furnishing doctors to meet the shortage.

Somebody has to make the decisions as to whether or not a young man under 37 years of age, in industry, who is a physician, is more important to that industry or more important to the armed forces. That decision cannot be made by the man who employs that young doctor in the industry. That decision must be made by an agency which is able to look at the matter in a completely unbiased way.

SENATOR PEPPER: *Would that agency be the armed service?* DR. FISHBEIN: No, by no means.

SENATOR PEPPER: *Aren't they the ones now making it?* DR. FISHBEIN: No, sir. The President's directive to the Procurement and Assignment Service and to the Office of Defense, Health and Welfare, which was Mr. McNutt's office at the time because that was before there was a War Manpower Commission, the President's directive to them said that they should have the consideration of an overall distribution of doctors to meet the needs of the armed forces, of industry and of the civilian population. And simultaneously with that there went an order to the Army Medical Department, the Navy Medical De-

partment, the United States Public Health Service and all other agencies employing physicians telling them that this agency had been established by order of the President for that job, and that they would submit their requirements to the Procurement and Assignment Service, which would aid them in meeting their needs.

SENATOR PEPPER: You indicate, then, that the President intended that the Procurement and Assignment Service should act as the overall agency for the selection of medical personnel, but you don't mean to say that they have performed that function, do you? DR. FISHBAIN: They have performed it within the law as it now stands, which puts the burden of ultimate decision regarding any man's service, when that man is under 45, on the local draft board.

SENATOR PEPPER: Well then, the matter has not been decided by the Procurement and Assignment Service under the War Manpower Commission, it has been decided by the local service boards? DR. FISHBAIN: The local draft boards. All matters of essentiality and the ultimate decision of forcing a young doctor into the Army have rested with the local draft boards.

SENATOR PEPPER: So the President's directive has not been carried out, it has not been effective? DR. FISHBAIN: It has been more effective in relationship to medicine than any similar effort in relationship to anything else.

SENATOR PEPPER: Well, in spite of that fact you have some states where more than 200 per cent of the quotas of the doctors have been taken in, and in a state like South Carolina you have 170 per cent and in a state like Alabama 190 per cent who allowed that to happen? DR. FISHBAIN: Well, it is still a free country—that is what permitted it to happen. The fact is that a man under 45 is under the control of the Selective Service board; a man over 45 is not under anybody's control in the United States.

SENATOR PEPPER: (interposing): They were allowed to volunteer, then? DR. FISHBAIN: Yes.

SENATOR PEPPER: Was that decided by the Procurement and Assignment Service or by the armed forces accepting them? DR. FISHBAIN: The armed forces obviously accepted them. But keep in mind your dates again! Keep in mind that the directive for the Procurement and Assignment Service did not begin until the end of October, 1941.

SENATOR PEPPER: How many doctors had been taken in by that time? DR. FISHBAIN: I will have to submit these individual figures to you; they are all here on the tables, and I will answer all your questions when I get the record.

SENATOR PEPPER: Roughly how many had been taken in? DR. FISHBAIN: Into the Army and Navy by October 1, 1941?

SENATOR PEPPER: Yes. DR. FISHBAIN: I would say roughly between 15,000 and 20,000, and 20,000 more came in between January, 1942 and September, 1942.

SENATOR PEPPER: So that the shortage that the civilian population now experiences is due to the number that have gone in since that time, substantially? DR. FISHBAIN: Very likely.

SENATOR PEPPER: And now the question is as to whether we are going to allow that hit and miss system to continue to operate, or whether the President's directive is going to be made effective and some overall agency shall determine the needs of the Army and the needs of the civilian population? DR. FISHBAIN: I would say that it operates effectively except for the unpredictable actions in certain areas of local draft boards. It operates effectively now; it didn't operate effectively before.

SENATOR PEPPER: You mean that it operates effectively only to the degree that the local draft boards and the armed services allow it to operate? DR. FISHBAIN: The armed services are giving complete cooperation—

SENATOR PEPPER: (interposing): They are not giving complete cooperation if the draft boards which represent the Army are doing something that is not a part of a comprehensive plan for the whole country. DR. FISHBAIN: I would say that to the extent—

SENATOR PEPPER: (interposing): The truth of the matter is that we haven't had a plan so far; the President may have intended to set up one when he created the Procurement and Assignment Service, but to a few days ago, at least, there hasn't been a national plan for the Procurement and Distribution of doctors to assure public health to the civilian population? DR. FISHBAIN: I don't think such a statement could be made with all the facts before you.

SENATOR PEPPER: Where has it been operating, then? DR. FISHBAIN: Suppose we had done what we did in World War I—

SENATOR PEPPER: (interposing): I am not asking you

to suppose. Where has there been an overall authority that has been looking at this picture as a whole? DR. FISHBAIN: You mean an authority to pick up doctors and move them around?

SENATOR PEPPER: To say what doctors shall come in and what doctors shall stay out. DR. FISHBAIN: The recommendation has been made in innumerable instances that certain doctors stay out, and the vast majority of Selective Service boards have respected those recommendations.

SENATOR PEPPER: But they were pure recommendations and didn't have any authority? DR. FISHBAIN: Only recommendations.

SENATOR PEPPER: Now, Doctor, to get back to this group health insurance. You heard the testimony of Dr. Garfield that the head of Procurement and Assignment in the state of Washington raised objection to their medical facilities being extended to the members of the families of their employees. Are you prepared to state from personal knowledge that that is not the fact? DR. FISHBAIN: No, sir; I would like to look it up, though.

SENATOR PEPPER: All right, you have that privilege I am sure.

DR. GARFIELD: Incidentally that is not only on the prepayment plan, but they wouldn't let us take care of them as private patients.

DR. FISHBAIN: I would like to ask you who stopped you, Doctor, from taking care of anybody? Did you try to take care of civilians and have them stop you?

DR. GARFIELD: We were afraid to because they said— DR. FISHBAIN: (interposing): Oh, now, Mr. Kaiser wouldn't be afraid.

DR. GARFIELD: They stated that if we were to do that they would declare our doctors nonessential; they were cooperative up to that point.

DR. FISHBAIN: Did you read that part where they said they would declare your doctors nonessential? DR. GARFIELD: No.

DR. FISHBAIN: You haven't that in writing? DR. GARFIELD: No.

SENATOR PEPPER: Doctor, let me ask you this. The man who is reputed to have made that statement was head of the Procurement and Assignment for the state of Washington? DR. GARFIELD: Yes, sir.

SENATOR PEPPER: He had the power to make recommendations as to who was essential and who was nonessential as a doctor, did he not? DR. GARFIELD: Yes, sir.

SENATOR PEPPER: And that was the only governmental agency there was to make such recommendations, was it not? DR. GARFIELD: Yes, sir.

SENATOR PEPPER: And you assumed that if the doctors had violated the restraint that he had imposed, he would have had the power to have recommended that they be regarded as nonessential? DR. GARFIELD: Yes, sir.

SENATOR PEPPER: And that that recommendation would have been observed by the War Manpower authorities and by the Army Recruiting Service, emanating from Washington? DR. GARFIELD: Yes, sir.

DR. FISHBAIN: I would say that no man has that authority; that he has never been given any such authority by any agency that I know anything about.

SENATOR PEPPER: You mean that the Procurement and Assignment representatives in the States do not recommend as to whether a man is essential or nonessential? DR. FISHBAIN: They have no authority to say to any man: Unless you do thus and so I will make you essential.

SENATOR PEPPER: Do they have the authority to recommend to the Selective authorities those who are essential and those who are not essential? DR. FISHBAIN: They recommend—

SENATOR PEPPER: (interposing): They do have that authority? DR. FISHBAIN: They recommend under an established policy of the national Procurement and Assignment Service.

SENATOR PEPPER: But they do have the power to go into a community and say "That man is nonessential" and "That man is essential" and to make that recommendation to the Selective Service authorities? DR. FISHBAIN: They have that authority.

SENATOR PEPPER: Now if that official chose to give furtherance to a policy of the American Medical Association against the particular kind of group health, and if he was, in furtherance of that desire, to designate a certain doctor as being nonessential, in all probability you say that the local draft board would take that man into the service if he was within the eligible age limit? DR. FISHBAIN: I will have to come back first to the statement that the American Medical Association has such a policy—they have no such policy.

SENATOR PEPPER: I am not asking you that. I ask if

that Procurement and Assignment official were to make that recommendation to the Selective Service authorities that a particular doctor was nonessential, would the Selective Service authorities not in all probability take that man into the service? DR. FISHBEIN: That is correct.

SENATOR PEPPER: Do you think it is wholesome public policy for the government to have as its representative in the selection of medical personnel a man who is in a position, at least, to further private interests by what he does? DR. FISHBEIN: Well, that would involve, if a different policy was adopted, the destruction of the entire Selective Service system.

SENATOR PEPPER: Would it be the Selective Service system or the system of the American Medical Association that would be disrupted? DR. FISHBEIN: The American Medical Association has no system in relationship to these matters.

SENATOR PEPPER: No. I am asking you would it not be appropriate for decisions of that character to be made by some official who has no personal or professional interest in the matter? DR. FISHBEIN: The decision now rests with the Selective Service, which determines whether or not the man is or is not essential.

SENATOR PEPPER: But the Selective Service, as you have said, in the selection of medical personnel relies on the recommendations of the Procurement and Assignment Service? DR. FISHBEIN: I would say that in many instances they consider that that is authoritative, reliable evidence.

SENATOR PEPPER: If they do—and you put into that place a representative of the American Medical Association—that man has the power, at least, by his action, to further a personal and professional interest, does he not? DR. FISHBEIN: I would say that wherever you put a dishonest man or one who does not deal justly, you have trouble.

SENATOR PEPPER: But, generally speaking, you try to disassociate a public official's functioning with his personal interest, do you not, or from his personal interest? DR. FISHBEIN: I venture to say that practically every representative physician, whether or not a member of the American Medical Association, who today is charged with the duty of declaring that some men are essential and others are not essential, is carrying that out in a more high-minded and idealistic way than it possibly could be carried out by any other official.

MR. KAISER: Senator Pepper, I think that the Doctor would be glad to know this: This is a conversation between Dr. Cutting and Dr. Fletcher, who is chairman of the State Procurement and Assignment Board of the state of California, and I will read just a portion:

Dr. Fletcher said that, as for the program [speaking of our program] as a whole, it was not his place or jurisdiction to question the ethical end of it although he was against corporation medicine of which this is a type [this is right along the lines of your thought]. He thought that the California Physicians' Service and medical profession themselves should take care of it. If this group (which is our group) went into the coverage of the new housing projects going on in Richmond, he would be very much opposed to it.

DR. FISHBEIN: He has a right to be opposed to it.

MR. KAISER: Now you maintain that he is not human and being opposed to it would therefore, even though he is not human, and being seriously opposed to it—we have frankly felt very much his attitude of opposition. I don't declare him dishonest, but he is not in favor of it and still he governs, through his recommendations, the men that we can or cannot have, and Dr. Garfield feels that he is doing him a great harm.

DR. FISHBEIN: I will say again, and say it as simply as possible, that an attempt has been made, as nearly as I can judge it, from observing what has been done, an attempt has been made to administer this recommendation of who is or who is not essential in a certain area, with strict regard for the functions that the physicians were carrying out I could give you innumerable cases. It is without regard to any question of competition in practice, distribution of practice, among the people who remain, or any such matter.

But the policies of the Procurement and Assignment Service on a national scale have held that inasmuch as this is a war in which primarily the services of younger men are needed with troops in the field, that young men under 37 years of age who take full time positions in industry, in teaching, in research, with medical organizations or in any other way, and because they are holding such a position avoid being called into active service with the troops, that those young men must be subject to some higher agency than the industry itself. They have adopted a policy. When you could show that a

young man—as in the case of Dr. Garfield, who is himself a young man—when you can show that a young man is your key man, that is all very well. But when you have a doctor under 37 years of age and you hold him because he is a specialist in nose and throat diseases, or you hold him because he is a specialist in urology, or you hold him because he is a specialist in obstetrics and a part of your organization, then obviously this higher agency which is looking toward the fact that we must win this war as our prime effort, and that we have to have young men to win the war, simply has to decide on a different level . . .

DR. LAMB (interposing): There are already 40,000 doctors in the armed forces. If we maintain the present ratio, and there is to be a seven and a half million army we will have over 70,000 doctors in the armed forces, and if we have a 10,000,000 man army we shall have over 100,000 doctors in the armed forces. What would you say the proper ratio of doctors to the population, which was the absolute minimum, and how much further can we go in that direction? . . .

DR. FISHBEIN: I would say that it is within the authority of the Army to change its ratios any time they find it is necessary or desirable.

DR. LAMB: Would you have any opinion with respect to desirable ratios?

DR. FISHBEIN: I would not have the impudence to say that. I would say to the Army, "The situation in civilian life is becoming critical and will you, if it is at all possible, economize on your use of doctors so as to leave the utmost possible for the civilian population?"

DR. LAMB: How recently have you said that to the Army?

DR. FISHBEIN: I must have said that in personal conversations or in writing many times.

DR. LAMB: What was the first date at which you said that?

DR. FISHBEIN: Well, I think the first date at which I said it was in 1940, in June, when we had a joint meeting with representatives of the Army and Navy and the United States Public Health Service, at which time we pointed out that we had just so many doctors and that sooner or later we would have to have definite quotas for each group to be served, the armed forces and the civilian population. . . .

DR. LAMB: How would you revise them immediately? DR. FISHBEIN: Already, wherever a shortage of physicians has been made clearly apparent—and we are conducting, incidentally, innumerable surveys, I have here the survey of the Public Health Service, of the Bureau of Economics, of the Procurement and Assignment Service, surveying all these areas—

DR. LAMB (interposing): But your decisions with respect to these surveys have been made on the previous assumption that the ratio of 1 to 1,500 for the United States as a whole can be applied in some fashion to these areas of shortage? DR. FISHBEIN: I believe, if you had asked Dr. Lahey that, he would have told you that that was certainly not the concept. Just yesterday the Committee on Allocations of the Procurement and Assignment Service determined that in any area where such a decision had to be made where there was a large city, and then a big rural area where you might get to 1 to 7,000, that obviously you would have to correct all your figures on that area on the basis that the large city was sucking in all the doctors and that special arrangements had to be made to meet those rural situations.

There is a physician in North Dakota who serves a rural area. He serves a radius of over 200 miles from his office. The only way he can serve that, obviously, is by motor car. If you today took that away, he couldn't serve any of the area except what was right next to him. The only way he can serve that area by motor car is to travel as rapidly as he can possibly travel, and to have snow-tires in winter, and to have enough gasoline to permit him to move. Unless you grant that doctor extra snow-tires in addition to the five tires that he is allowed, and unless you grant him enough gasoline to cover his area, you decrease his capacity by 90 per cent.

DR. LAMB: Yes, Doctor.

DR. FISHBEIN: Now there are federal agencies which have already forbidden him to have snow-tires; they said, "If you get two snow-tires you will have to give up two of your other tires." . . .

SENATOR PEPPER: It is interesting that you, in your capacity as a paid representative of the American Medical Association, would exhibit the initiative that you—DR. FISHBEIN (interposing): I have always exhibited the utmost initiative of which I am capable in matters affecting the public health.

SENATOR PEPPER: I think the poor condition of public

health in the United States probably proves you are correct in what you have said. DR. FISHBEIN: Now the next step, Senator Pepper, concerns a doctor who is a pediatrician in a small town in Illinois. He draws his pediatric practice from an area in that neighborhood of a little over a hundred miles. The farm women bring in their babies to this pediatrician. As far as I know, no method has been provided for permitting farm women to bring their babies in to where the doctor is. In other words, they also must exceed their total ration of gasoline in order to bring the baby to the doctor.

DR. WEBER: Are pediatricians being taken into the Army? DR. FISHBEIN: All classes of doctors are being taken into the Army. . . .

MR. KAISER: The Doctor has intimated that he would emulate my technique in getting results by threatening publicity. I think that brings home a very important question, because if he really believes in that policy, possibly the medical profession or medical society must likewise believe in it, and that justifies the position that we have been holding. My feeling is that any one who, by threatening publicity, accomplishes anything both should be removed from the service of their country. I likewise feel that way both about myself and the medical association, if that is the policy they follow.

DR. FISHBEIN: If we assume that the people of this country are the ones who run the country, the people must know. And the only way to get action is to let the people know. If you have an area in which there is a shortage of doctors and you want doctors, you have a right to let the people know that you are short of doctors. And then if you attempt various strong arm methods to accomplish things that are outside the law, and any newspaper finds that out, they have a right to let the public know.

SENATOR PEPPER: If the American Medical Association finds a deficiency in doctors in the country, are you going to give publicity to that deficiency and use the full glare of the spotlight of publicity to remedy that condition? DR. FISHBEIN: We are doing that all the time.

SENATOR PEPPER: And if you should find that group insurance of a legitimate character would be a method of using more efficiently the medical talent and personnel of the country, are you going to use that same publicity to achieve that purpose? DR. FISHBEIN: We not only have used the publicity but we have adopted the policy. There are thirteen state medical societies that have set up such plans, there are over three hundred counties that have set up prepayment plans for supplying medical service. We probably have failed in our publicity in not letting enough people know that the medical profession is itself working out these plans.

SENATOR PEPPER: If you find instances in which members of the Procurement and Assignment staffs have used their public position and power to serve private end, are you going to give the spotlight of publicity to that? DR. FISHBEIN: I would be the first to recommend removal. If it came to my personal knowledge that any doctor endeavored to coerce Dr. Garfield by saying to him, "You will either do this or you will be marked essential for military service." I would be the first to recommend that that man be removed from the position.

SENATOR PEPPER: And if you found that there was an appreciable danger that that position was being abused to serve private ends, then you would recommend the reexamination of the policy of using such personnel in a government position? DR. FISHBEIN: If I found that any system was capable of coercion in what is presumed to be a democracy, I would recommend a change in the system, because I have always been a believer in democracy.

SENATOR PEPPER: Do you regard the American Medical Association as a perfect example of democracy in its functions? DR. FISHBEIN: I would say that it is organized like the United States government, and it comes as near to functioning like a democracy as the government comes to functioning as a democracy.

SENATOR PEPPER: Thank you very much, Doctor.

NOTE. FOR NEWSPAPER REFERENCES TO THE "PEPPER HEARING," SEE "MILITARY CLIPPINGS," WHICH FOLLOW.

What Can War Manpower Commission Do?

Here are some questions and answers in connection with Paul V. McNutt's new powers as chairman of the War Manpower Commission:

Q. What is the WMC's overall function?

A. In the language of President Roosevelt's execu-

tive order of Saturday, "to promote the most effective mobilization and utilization of the national manpower and to eliminate so far as possible waste of manpower due to disruptive recruitment and undue migration of workers."

Q. Over what does WMC now have supreme authority?

A. Over all matters pertaining to procurement of manpower, military and civilian.

Q. Through what agencies will WMC exercise its new powers?

A. Chiefly through the Selective Service system and U. S. Employment Service, both of which WMC now operates.

Q. What persons are affected by the new grant of powers?

A. Everybody, man or woman. McNutt said he considered the entire population "a national pool" from which military, industrial and agricultural manpower needs will be filled. His guiding principle will be "to enable each man and woman to use his or her best abilities and skills where they will contribute most to the war effort."

Q. How will the new set-up affect procurement of men for the armed services?

A. Henceforth all services will obtain the bulk of their new manpower through Selective Service. Voluntary enlistments are terminated for men 18 to 38. The Navy may continue to recruit 17-year-olds and men 38 to 50. The Army does not accept men under 18 and, under a recent War Department ruling, will not take men 38 or older unless they are urgently needed because they possess certain special skills.

Q. How will the new induction rules affect applicants for commissions?

A. The Navy will continue to accept applications from men in the 18-38 category. It will not, however, continue to enlist officer candidates and permit them to continue in college. The War Department is still working out details of its new induction policies. The 38-year-old rule, however, will not affect volunteer officer candidates who have been accepted but not yet called. Such men will be inducted when the Army is ready for them, as in the past.

Q. Why are voluntary enlistments terminated?

A. Enlistments, McNutt said, have resulted "in the withdrawal of so many skilled workers as to threaten production of vital war materials." His aim is to allocate manpower between industry and the armed services "in an orderly process."

Q. Why has the War Department decided to discontinue accepting men 38 or older?

A. The Army found that men above that age, although passed by medical examiners as physically fit, cannot stand up under the rigors of army life.

Q. How will individual registrants be affected by the new orders?

A. The SSS and USES will review records of registrants to determine how their abilities may be most effectively used.

Announcing the Closing of the Medical Officer Recruiting Board (COPY)

HQRS. MEDICAL OFFICER RECRUITING BOARD
Northern California, 450 Sutter St.
San Francisco, California.

No applications for commission can be accepted by this Board after December 15, 1942. Doctors who have not applied may do so up to and including that date.

All applications already made and now in process should be completed by December 15, 1942. This will be accomplished if requests from this Board to Doctors concerned receive prompt attention.

This Board, in closing, wishes to express its appreciation to the Medical and Dental professions for their cooperation.

(Signed) H. SCHWARTZMAN,
Major, Medical Corps,
President of the Board.

British Experience in Civil Defense

(COPY)

OFFICE OF CIVILIAN DEFENSE

Washington, D. C.

(Circular: Medical Series No. 20)

To: Regional Directors and Regional Medical Officers.

FROM: DR. GEORGE BAEHR, Chief Medical Officer.

SUBJECT: Lessons From British Experience in Civil Defense.

Special Distribution Instructions: To State and Local Councils.

Three years of British experience with air raids have significantly modified earlier concepts regarding the field casualty services. The following observations made on a recent inspection of emergency medical facilities in England and Scotland are forwarded for your information and for transmission through State Chiefs to local Chiefs of Emergency Medical Services.

1. *Heavy raids occur invariably at night*; heavier high-explosive bombs and land mines are now being employed, up to 2,000 kg., with much greater destructive effects. Incendiary bombs are used in much larger numbers, and fire is now the most serious hazard. Daylight raids are usually hit-and-run affairs in which solitary planes participate.

2. *In large cities* the field casualty services may handle 2,500 to 3,500 casualties during a night raid. All serious casualties are moved directly to hospitals, never to first-aid posts. Heavy raids are apt to be repeated on subsequent nights when the protective forces are exhausted.

3. *A large fleet of four-stretcher ambulances is essential for life saving.* Fourteen thousand ambulances were made in England and Scotland by purchasing used cars, stripping them, and then mounting a simple ambulance body on the chassis. London uses over 1,500 of such ambulances and 550 sitting-case cars. The use of tradesmen's trucks proved universally unsatisfactory; 3 out of 4 never arrived on the scene, and lives were lost due to the delay and confusion. Because of the large number of casualties to be transported in a few hours, no ambulances which carry less than 4 stretchers are employed. For the simultaneous evacuation of damaged hospitals, a fleet of 200 converted busses carrying 10 stretcher cases and 6 to 10 sitting cases are immediately available, and another 200 are obtainable within 2 hours.

4. *Casualty stations (British fixed first-aid posts) are necessary* at or near all hospitals and at places more than a mile from hospitals to care for minor casualties which do not require hospitalization. Many are now on a care-and-maintenance basis and are activated only during a raid. When functioning, the staff usually consists of one or two doctors, several nurses, and a variable number of aides and auxiliaries.

5. *In large cities casualty stations need not be more numerous than 1 per 25,000 inhabitants*; they should be located about a mile apart. There are less than 300 in the London area, with a population of about 10,000,000 and a land area more than twice that of Greater New

York. In smaller, thinly settled communities, they are more numerous in relation to population, but the distances between them are proportionately greater than in metropolitan cities. Many of the minor casualties are moved to first-aid posts in sitting-case cars; some walk.

6. *First-aid parties (our stretcher teams) are not necessary*, are a waste of manpower, and are rapidly being eliminated. First aid at incidents is essentially a function of the rescue parties (our rescue teams), which extricate the casualties from under the debris of demolished buildings. All first-aid parties in England and Scotland are, therefore, being merged into the rescue parties. They include a leader, an assistant leader, and eight other members, and are entirely independent of the fire department. They are a life-saving service related to the medical services concerned in field casualty work.

7. *The experiences of Britain under air-raid conditions* have dispelled many preconceived notions concerning first aid. Almost all raids occur at night; the victims are crushed under the debris of demolished buildings and are either dead or severely injured; less than a third are slightly injured and can be cared for at casualty stations; all the severely injured must go to a hospital; victims are invariably covered with dust and dirt which hangs in the air for hours. The conditions under which the rescue workers encounter the injured beneath the structural debris, the darkness and the dust which always fill the air, the large proportion of dead and severely injured, and the urgent need for immediate hospitalization make it impossible to apply most peacetime concepts of first aid.

8. *Wounds are usually grossly contaminated* and need only be covered with a shell dressing until the casualty reaches the hospital. Hemorrhage is usually controllable with a pressure dressing. The tourniquet is rarely employed. Burns are covered only with sterile gauze until the casualty arrives at the hospital. Tannic-acid jelly as a first-aid dressing for burns has been discarded because of the dirt which invariably contaminates the burned surface, because the jelly deteriorates rapidly, and, lastly, because tannic acid ignites in the presence of phosphorus when applied to burns caused by the explosion of phosphorus-oil bombs.

9. *Traction splints are not used.* An exception is made if the casualty must be transported a long distance over country roads. Unlike Army field experience in the last war, the few miles of travel to a hospital over the paved roads of a city do not warrant the application of traction, especially as the darkness and the conditions of an air raid also make hurried application of the procedure difficult or impossible. All that can be done is to place the fractured extremity gently in alignment, bind it with triangular bandages to the uninjured leg or to an improvised splint, or apply a Thomas splint if one is on hand. Movement of the fragments can also be minimized by snug application of the blankets according to the Wainwright technique of blanketing and by the use of sand bags which should always be carried in the ambulance.

10. *Shock is treated at the incident* by prompt administration of adequate doses of morphine (up to ½ grain for adults), coramine, proper blanketing, administration of fluids, and the use of hot-water bottles during transportation to the hospital. The use of plasma or blood transfusion is deferred until arrival at the hospital: it is ordinarily quite impossible in the darkness, dirt, and confusion at the incident.

11. *The presence of a physician at the incident is invaluable*, but more than one is unnecessary. In fact, one physician may cover several nearby incidents, leaving his nurse or one of the nursing auxiliaries of his emergency team at the incident while he moves temporarily from one to another in the immediate neighborhood.

12. *Even though a single night's casualties requiring hospitalization may total one or two thousand, large hospitals rarely receive more than 50 to 100, the load being distributed as evenly as possible throughout the city.*

13. *A large casualty receiving hospital is often related to one or more peripheral hospitals in the suburbs or in a country district. There are now four base hospital beds for each casualty bed in the cities.*

14. *Upon receipt at a local report and control center of a message from an air-raid warden that an incident and casualties have occurred, an "express party" is immediately dispatched to the scene. An "express party" includes one rescue-first aid party, one ambulance, one sitting-case car, and one mobile medical unit (our mobile medical team). The latter consists of one physician, one nurse, and two auxiliaries. No other equipment and personnel of the emergency medical service is dispatched unless additional assistance is requested by the incident officer (usually a higher police official) or by the incident physician on the scene. In this manner useless movement is avoided and equipment and personnel of the community is carefully conserved.*

Tales of Heroism

Medical Officer Tells of Men Under Fire

The cruiser San Francisco's medical men returned here yesterday to add their tales of heroism—of heroism under the combined hells of shellfire and pain, of sacrifice, and inspired duty.

"One Negro mess attendant," revealed Lieutenant Commander Edward S. Lowe, medical officer, "was standing in an exposed position during the battle.

"He deliberately got in the line of fire to protect a hospital corpsman taking care of a patient. He was killed."

The mess attendant was awarded the Navy Cross posthumously.

Commander Lowe, of Costa Mesa, California, himself awarded the Navy Cross for heroism under fire, declined to describe the reasons for his own award.

"Let me tell you about one of my corpsmen," he said. "He was shot in the leg and put out of action—but he cared for patients at his own request, in spite of his wounds.

"Another man, shot in the hand, took care of the wounded until he collapsed 36 hours later from exhaustion and his infected wounds."

Practically every dressing station was sprayed with Japanese metal during the battle of the Solomons, he declared.

"The fortitude of the wounded men brought to battle stations was wonderful. The morale was far above anything I ever expected."

Other officers and enlisted men praised Commander Lowe for his own personal gallantry and apparent fearlessness during the night of battle.

"If it hadn't been for the doc," one seaman declared, "there are a lot of us here today who otherwise would have been buried down there. Boy! he sure worked miracles by the carload!"

The Commander declared many of the wounded men survived as a result of the literally wholesale use of blood plasma and sulfa drugs for battle shock, burns and infections.—San Francisco *Chronicle*, December 12.

4 Million Men Facing Draft Call in 1943

'Teen Age Induction Starts in January; Dependency Group Up in Few Months

Washington, Dec. 12—(INS.)—The War Manpower Commission announced tonight that a minimum of 350,000

men a month would be called into the armed services in 1943, and that married men would be inducted generally "before many months."

In a series of questions and answers on the draft, the Commission said that men with collateral dependents only, such as father, mother, etc., would be called first when it becomes necessary to tap the dependency groups.

Thereafter, men will be called from the dependency groups in the following order:

1—Married men with dependent wives only.

2—Married men with wife and children, or children only.

However, men not in essential industries or essential agriculture with dependents will be called ahead of men in essential industries with dependents. . . .

The commission said that the actual number of men to be called was a military secret, but that official estimates indicate a minimum of 4,200,000 in 1943, or 350,000 per month. These figures do not take into account replacements, the commission explained, so that the actual figure presumably will be higher.

This country probably will not, while the war lasts, reach a saturation point where it will need few additional soldiers, the commission said, since replacements will be required as long as the Nation is at war.

900,000 in 'Teens

Induction of 18 and 19 year olds will start in January, the agency pointed out. These boys will be called in the order of their age, beginning first with those who are nearly 20 years of age, and working down.

The number of 18 and 19 year olds available for early calls ranges from 600,000 to 900,000. They will not entirely fill the quotas for the early months of 1943.

Experience has shown, the commission said, that there are seventeen or more different classifications of married men for draft purposes, and local boards will use "their best judgment" in determining the precise order of their induction.

The commission pointed out, however, that the calling of married men with dependent children requires specific authorization by Maj. Gen. Lewis B. Hershey, director of selective service. No such order has been issued as yet.

New Class; 4-H

Although men may express a preference for the Army, Navy, etc., they will be assigned according to the needs of the various services and on the basis of individual skill and experience.

Men between the ages of 38 and 45, no longer to be inducted as a result of lowering the age limit to 38, will be placed in a new classification—4-H. They could be available for armed service if the President should rescind his order.

No effort will be made to force them into essential industries, but the commission hopes most of them will find jobs in war industries.

Local boards have been instructed to reclassify men with collateral dependents only, and married men without children, into Class 1-A, thus making them available for call.—San Francisco *Examiner*, December 13.

Military Clippings—Some news items of a military nature from the daily press follow:

Country Club in Alameda County Turned Into Navy Hospital

Heroes of Pacific Battles Aided to Recovery by Peaceful Life Among Hills of East Bay

The peacetime playland that was the Oak Knoll Country Club has become a wartime haven for the wounded of the South Pacific.

Sailors and marines, officers and men who have looked on the face of the enemy and felt the fury, loaf in the sun, now, where Sunday golfers used to curse the sand traps.

Sixty new buildings, sheltered in a fold of the eastbay hills where the country club's greens and fairways used to be, have been completed at the site since spring. Commissioned in July, the hospital, one of three Naval hospitals in the bay area, now houses between 800 and 900 patients. It will accommodate slightly more than 1,200 when completed. Other Naval hospitals are at Mare Island and Treasure Island.

Long Convalescence

Because only completely well men can take part in active duty, military hospitals accommodate their patients through long convalescent periods. Almost two-thirds of the Oak Knoll patients are able to be up and about by now—"and they enjoy the hills, the view, and watching the new lawns come up," their doctors explained.

For staff, the hospital has some fifty medical men, each a specialist, besides, Navy nurses and members of the Navy medical corps.

Heroic Surgeon

Matching the heroes of the present war—dozens of them in any direction, at Oak Knoll—is the medical officer in command, Capt. Frederick R. Hook, who was a young surgeon when he joined the Navy in April, 1917, and came home from Europe in 1919 with a Navy Cross, a Distinguished Service Cross, a Croix de Guerre, assorted citations, and the right to wear the Fourragere the French Government awarded to the Fifth United States Marines.

The hospital has elaborate equipment—operating rooms capable of taking care of a dozen or so cases in a morning; elaborate x-ray photographic and treatment units; a man-size fluoroscope; therapy equipment; light, airy wards with sunrooms; laboratories and a pharmacy, and mess halls for the patients who are almost well. The old clubhouse has become a recreation center, with a library, a soda fountain, a barber shop and the like.

Heroes Recovering

A few local casualties—men stationed in the Bay area who had arguments with motorcycles, or were hurt in other accidents, are under treatment at Oak Knoll. But most of the patients are already on the way to recovery, after preliminary treatment at advanced base hospitals, by the time they reach the East Bay institution.

In the last group are men like the highly indestructible Eugene Moore—the marine who didn't realize a mob of Japs had "killed" him at Guadalcanal—and Carl Greer, fireman, first class, aboard the Yorktown, who jumped seventy feet into the sea with a wounded comrade in his arms, and acquired two broken legs and a ruptured diaphragm.

Both Moore and Greer are getting well. They'll be out admiring the new lawns, pretty soon.—San Francisco Examiner, November 14.

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Physician Allocation Not Urged by Health Service

Washington, Nov. 4—(UP.)—Surgeon-General Thomas Parran of the United States Public Health Service, says he is not in favor now of compulsory allocation of physicians.

Parran testified before a Senate education and labor subcommittee which is investigating methods to protect the health of the country by possible enactment of a national service act for the medical profession.

"I am not prepared at this time to recommend the allocation of doctors by a national service act," Parran said. "We may need to come to that on the medical front in order to alleviate the serious depletion of doctors in many areas, but I would not endorse any compulsory legislation affecting the medical profession at this time."

Heatedly disagreeing with Parran was Dr. Paul de Kruif, author of medical books written for laymen, who denounced "white-wash" methods of the American Medical Association and recommended federal supervision over allocation of all members of the medical profession.—Alameda Times-Star, November 4.

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Army, Navy Get Doctor Quotas for Rest of 1942: A.M.A. Conference of State Association Secretaries and Editors

The Army and Navy have obtained all the medical men they have requisitioned up to January 1, Dr. Frank H. Lahey, chairman of the board of procurement and assignment service for physicians, dentists and veterinarians, said here today. But this, he indicated, was achieved with the aid of states which exceeded their quotas and made up for the shortages of Illinois and four other states.

Dr. Lahey made his report at the annual conference of secretaries and editors of state medical associations at the headquarters of the American Medical Association.

The other states that have not met their quotas, he said, were California, Connecticut, Massachusetts and New York. He explained that the plans for allocating doctors provide that there shall be one doctor for each 1,500 civilians.

No Additional Drawing

"There will not be any additional drawing for the armed services that have exceeded their quotas till the others have been brought up," said Dr. Lahey.

Dr. Lahey added for the encouragement of civilians that the ratio of one doctor to 1,500 civilians, which will be preserved as long as possible, is relatively generous by comparison with the ratio of other nations. In England the present ratio is one to 2,700 and in Germany, one to 12,000.

"In the United States before the war," he said, "in some cases, in congested cities, there was one doctor to 500 patients, and in some rural areas, as few as one to 2,500."

Divided Into Two Classes

"The medical population of America has been divided into the doctors essential in the civilian community and those available for the armed forces. Thus far 218 physicians have been relocated in 154 communities in 29 different states."

All needs have been met by the voluntary system, and Col. Fred W. Rankin, president of the American Medical Association and a reserve medical officer, expressed the hope that there would be no drafting of physicians for professional purposes "until all elements of the population are placed under draft regulations."

Rear Adm. Ross T. McIntire, surgeon general of the U. S. Navy, urged that planning begin now for low-cost medical care after the war, "when money will be scarce."—Chicago Daily News, November 20.

* * *

Manpower Problem

9,700,000 Men in the Services by End of 1943

Washington, Nov. 10—(AP.)—President Roosevelt, asserting that something must be done about the manpower situation in the next two or three weeks, disclosed today that the fighting forces will number about 9,700,000 men by the end of 1943.

Between now and that time, he said at a press conference, the Nation must find four or five million more men—the best young manhood—for the armed services. Simultaneously, he added, it must find men to take care of the food problem and industrial production, which is still short of its peak.

His statement came in response to a question whether he favored transferring the selective service system to the War Manpower Commission, as recommended by a management-labor policy committee of WMC. It was, he said, all part of the manpower question. He has been devoting a lot of time to that problem. There was no immediate emergency, but something must be done in two or three weeks.

As for the armed forces, there were now, he said, about 4,500,000 in the Army, which must be increased to about 7,500,000 by January 1, 1944. Meanwhile, the Navy's present 1,000,000 must grow to 1,500,000, and the Marine Corps and Coast Guard must be increased from 400,000 to 700,000.

Getting down to actual numbers for the combat forces, the President said tens of thousands of additional men were being added each month for the fighting forces and to hold bases already acquired.

Going along on an orderly basis, he said it was planned to keep this increase rising until a goal of about 7,500,000 is reached. Mr. Roosevelt said he hoped that would be enough but that at present the Government could not look beyond January 1, 1944.

In increasing the Army, the President said it must be made sure that the men are well equipped and have the necessary munitions.

This meant, he added, that large numbers of people must be had from civilian life to make those supplies and equipment to keep pace with the orderly increase in the Army.

The same held true for the Navy and other fighting services, he said.—San Francisco Chronicle, November 13.

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18-Year-Olds Register for Army Dec. 11-31

Washington, Nov. 18—(INS.)—President Roosevelt today ordered that all youths who have become 18 years of age since last June 30 register for military service during the three weeks from December 11 to December 31.

It is officially estimated that there are 600,000 youths in this age bracket.

At the same time, the President in a proclamation

directed that during the rest of the war young men who were born after January 1, 1925, shall register for military service as soon as they reach their eighteenth birthday.

Three Registrations

Youths born during July and August will register during the week of December 11. Those born in September or October will register during the week beginning Friday, December 18. Those born in November or December will register in the week beginning Saturday, December 26.

U. S. Employees Liable

Selective service headquarters prepared to register the youths coincident with presidential orders cancelling draft deferments of government employees.

A "lot of men," not now in the draft because they are working at desks in crowded government offices in Washington and scores of other cities, faced induction into the army as the result of a White House directive.

The men—and it was estimated that there were enough to make up an entire division—saw induction near after President Roosevelt instructed the heads of all government agencies to cease asking military deferments from any of their employees.

New Draft Rules

At the same time, Maj.-Gen. Lewis B. Hershey, national draft director, instructed local boards to carry out the "teen-age" draft act by the following actions:

1. Deferment of farm workers, of all ages 18 to 45, who are necessary to and regularly engaged in work in war-essential agriculture.
2. Distribution of questionnaires to 18 and 19-year-old registrants, who will begin to be inducted as their order numbers are reached.
3. Deferment of high school students in the 18 and 19-year groups, if the students request it and if they are in the last half of the autumn-to-spring school years.
4. Deferment of all men who registered before age 45 who have passed their forty-fifth birthday since, unless they file their written consent to induction into the armed forces.

Two new classes, II-C and III-C, were announced for deferred farm workers. Those without dependent wives, children or other grounds for dependency deferment will go in II-C, those with dependency to III-C.

Month Before Induction

Selective service officials estimated that it would be at least a month before the first 18 and 19-year-olds are inducted. Questionnaires have to be mailed out, returned and classified. Ten days are allotted for returning the questionnaires.

Men who were 18 years old on last June 30 already are registered and will be inducted in the order of their birthdays. Another registration will be held in December for those who have reached the age of 18 since last June 30.

After January 1, selective service officials said, those who become 18 years old will register at local boards on their birthdays.

One spokesman estimated that there were 700,000 men available for the draft in the group who were 18 years old on last June 30, while approximately 1,000,000 men become 18 each year.—*Wichita Kansas Beacon*, November 19.

* * *

Manpower: We'll Have to Supply a 62 Million Fighting and Working Force by End of '43

America stands today in manpower problems where Germany stood five years ago, the Office of War Information reported yesterday, in announcing the United States faces a need of supplying a working and fighting force of 62,500,000 by December, 1943.

"Between June, 1940, and June, 1942, the number of persons in civilian employment and the armed forces increased from 48.1 millions to 57.1 millions," the statement said. "Of these, 5.8 millions came from the ranks of the unemployed, and most of the remainder represented the natural increase in the working force."

"To get an additional 5.4 million, the Nation must dip into its potential labor reserve of 31.9 millions—the 2,000,000 farm operators working submarginal land and producing only 3 per cent of the commercial farm crop, the 4.4 million nonfarm housewives under 45 with no children under 16, the 9.1 million nonfarm housewives over 45, and the 6.9 million students between the ages of 14 and 17."

"Germany exhausted such reserves years ago. Japan has been facing a critical labor shortage for two years. Japan drew her army from the agricultural areas and did not, therefore, disrupt her industrial functioning."

Japanese law permits children over 12 to work provided they have completed their compulsory education."

The statement said the problem facing the United States is to make a full utilization of local labor through training programs and advancement of minorities before calling upon outside labor and to prevent employers from luring workers from other and equally vital war jobs.—*San Francisco Chronicle*, November 9.

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Medical Science Will Protect American Troops in Africa

Richmond, Va., Nov. 10—(AP.)—Medical science has a "third front" established in Africa to protect our fighting forces there against a foe as dangerous as the Axis—tropical disease—Dr. Joseph S. D'Antoni, vice-president of the American Society of Tropical Medicine, said today.

"The men will be well protected; every precaution known to medical science has been taken," declared the Tulane University doctor in an interview at the opening of a wartime meeting of the Southern Medical Association with which his society is convening jointly.

Doctors Trained

"Long before our African campaign started," he said, "our Government had studies made of possible health hazards there and in other countries where our troops might be engaged, and trained doctors and sanitary engineers are prepared to cope with the situation."

Asserting that malaria and two forms of dysentery were the most important tropical problems, he said, "if our offensive action in Africa takes our troops into malarious country, they will be provided with anti-malaria drugs. There is a shortage of quinine, but we have another, atabrine, which is prepared in New York."

"Again, with regard to the dysenteries which result from tainted drinking water, sanitary engineers are prepared to rule various water supply sources 'out of bounds.'"

Under Control

He said vaccines were also available as protection against certain other tropical diseases which he was not at liberty to list.

The British have tropical diseases under control in Libya, said the doctor, adding:

"We can go back still further. Private communications received in this country report that during Italy's campaign in Ethiopia there was not a single fatal case of malaria due to malaria prophylactic measures directed by Dr. Castellani, medical director of the Italian Army."

"That was the first colonial war in the history of the world where tropical disease didn't produce more deaths than actual combat. And since that time there has been an increase in our knowledge of tropical diseases."—*Oakland Tribune*, November 10.

* * *

Ships' Doctors Unsung Heroes of U. S. Fleet

Sea Surgeons Think Nothing of Performing Major Operation Aboard Bouncing Warship

Aboard a Cruiser With U. S. Fleet, Solomons Area—(Correspondence of the Associated Press).—"Come below and watch us do an appendectomy," said the young medical officer.

It was 8 p. m. on a peaceful, moonlit night in the Solomons waters. It was not a peaceful night, however, to a young sailor who tossed in a bunk below.

In the operating room, two surgeons, several pharmacists' mates, and this correspondent put on white gowns and masks.

Surely, steadily, the two surgeons went at their task. They braced their feet, for there was a slight roll to the cruiser. We could hear the waves slap against the side of the ship.

Local Anesthetic

The sailor had wanted a local anesthetic and he got it. In the tropic heat, perspiration ran down the patient's face and down the faces of all of us standing around the operating table. One man was kept busy wiping faces with a cool rag.

This surgery at sea is routine to the doctors of the fleet—men who fight to save lives, not to take them. They think nothing of operations in a bouncing warship.

It was found that the young sailor's appendix would have ruptured by morning. Now he is making fast recovery, and soon he will be ready for another crack at the Japs.

These fleet doctors—many of whom gave up lucrative practices to join the Navy—have saved hundreds of lives since war began. This cruiser has taken aboard many injured survivors.

3 Days Without Sleep

On one occasion, a doctor worked on injured men for

three days and three nights without sleep—and only occasional cups of coffee.

Many of the survivors were more dead than alive when they were brought aboard and placed on the decks, in the hangars and sick bay. Some were injured, mangled and burned so badly that tough old sailors turned their heads away to avoid the sight.

But not a man died on this cruiser. All recovered, and the great majority are out again with the fleet.

"They were the bravest, finest patients a man could ask for," this doctor said. "They were typical of our American sailors."

"As far as glory goes, I don't think a man could want more glory than to see those men get well and return to their guns—able to use their arms and legs and muscles again!"

Always on Call

A physician is the closest thing to a mother that the sailors have aboard a warship. He's on call twenty-four hours a day to administer treatment, give advice and listen to complaints.

Except for an occasional appendectomy and colds, there is little sickness aboard the average United States warship.

"Our job is not so much to treat them, as to keep them well and in fighting shape," said the physician.

"Altogether, they are the healthiest bunch of men I've ever seen. Although they live in a space more crowded than the worst tenement district, the excellent sanitation of the ship and the personal cleanliness of the men tend to keep them healthy. Then, of course, they live a rugged outdoor life and they get lots of exercise and a well balanced diet."

Come in Threes

It was midnight when we decided to "hit our sacks," as they speak in the Navy of going to bed.

Just then an orderly approached and announced that another sailor had come to the sick bay with a "stomach ache."

"Probably another appendix," the doctor said over his shoulder as he started away. "They always come in threes. See you in the morning."—San Francisco Examiner, November 13.

1 1 1

Dr. Fishbein Defends A.M.A.

Washington, Nov. 6.—(AP.)—Dr. Morris Fishbein, editor of the American Medical Association's Journal, challenged charges of A.M.A. selfishness in the drafting of doctors for the armed services before a senate committee today.

At times, Dr. Fishbein engaged in spirited debate with Henry J. Kaiser, the West Coast shipbuilder, as to the deferment of doctors for the care of industrial workers.

Referring to suggestions for compulsory assignment of doctors to areas of few physicians, Dr. Fishbein said he opposed "certain proposals to meet the needs that are close to totalitarianism."

He declared that doctors of the A.M.A. in charge of the government's procurement and assignment service for the armed forces have carried out their duties "in a more highminded way than they could be carried out by any other officials."

A.M.A. Has Similar Service

He asserted that the A.M.A. itself had worked out plans to prepaid medical care and that 13 state medical societies had set up plans for this form of health insurance. This was in answer to a statement by Dr. Sidney Garfield, Kaiser's medical director, that Washington State Medical Society officials had threatened, in effect, to draft his company doctors if they served the families of workers on a prepaid basis.

"Have you got that in writing?" Dr. Fishbein asked.

"They wouldn't dare put that in writing," Kaiser replied.

Dr. Garfield told of conditions in Vancouver in relating why the company medical program included families of workers.

Under the medical program, the doctor said each worker desiring to participate pays 50 cents a week to get company medical care.

"Orally," Dr. Garfield told a senate labor subcommittee, "we were told that 'If you take care of the families, we will declare that your doctors are nonessential.'"

Washington State Group Blamed

Dr. Garfield said this "threat" was made by the Washington state medical society's executive committee. Under questioning by Senator Pepper (D.-Fla.), Dr. Garfield said the chairman of that committee also was state chairman of the government's service for the procurement and assignment of doctors for the armed forces.

Senator Pepper asked if "the same man who is supposed to represent the United States in the procurement of doctors for the army and navy" is taking "advantage of his position as a public official to promote the private interests of the medical association."

"That's it," Dr. Garfield said.

"So that public policy emanates primarily from a private source," Senator Pepper commented.

At another point, Dr. Garfield said the procurement and assignment service "represents the views of the American Medical Association."

'Army Has Enough Doctors'

"I don't want this interpreted as an attack on the medical society," Dr. Garfield said, "but it is hindering us from doing a necessary job."

Kaiser pointed out that the army has 40,000 doctors for 4,000,000 men, or one per hundred, while in his plant the "army of supply" had one doctor to every 2,000 men. —Pomona Progress-Bulletin, November 6.

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Medical Journal Hits Kaiser Setup

Chicago, Nov. 10.—(UP.)—The Journal of the American Medical Association charged in an editorial today that some physicians and industrialists, including Shipbuilder Henry J. Kaiser, desire to maintain intact their own staffs of doctors "regardless of the needs of the armed forces."

The Journal defended the work of the procurement and assignment service for physicians, dentists and veterinarians in allocating medical personnel for military, industrial and civilian needs and accused Sen. Claude Pepper (D), Fla., of calling before a senate hearing only such physicians and others who were dissatisfied with the procurement and assignment service.

Pepper, charged by the Journal with conducting a "one-man inquisition," heads the senate committee on education and labor now conducting hearings on the medical personnel situation.

"One of the chief facets thus far obvious (in the senate hearing) is the desire of some industrial leaders and of the full-time staffs of physicians which they employ to maintain their individual empires without disturbance regardless of the needs of the armed forces for physicians."

Scores Setup

"They believe apparently that individual physicians should be taken by the armed forces before clinics, private hospital staffs, industrial organizations or similar groups are in any way disturbed."

"Prime movers in an assault upon the procurement and assignment service" for its allocation of doctors, the editorial said, are Drs. Paul de Kruif and Michael M. Davis, Kaiser and the head of his medical services, Dr. Sidney Garfield.

"Already," the editorial said, "evidence has been submitted that the services established by . . . Kaiser, under the direction of . . . Garfield, and endeavoring to hold from the armed forces even the opportunity to determine for themselves whether or not the considerable number of young men employed on salaries by this industrial organization are fit and available for military service."

Blow to Morale

The Journal said a doctor's fitness for the military must not be left to his employers and should be determined by local draft boards upon advice from the procurement and assignment service.

"The performance displayed in Senator Pepper's hearings," the editorial concluded, "is not likely to improve the morale of American medicine at the very time when it should be at its highest in the service of the war effort." —Oakland Post-Enquirer, November 10.

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Doctor Draft Challenged By A.M.A. Journal

Procurement Census Made in 1940, Publication Points Out: Recruiting of Medics Hit

Chicago, Nov. 3.—(INS.)—The Journal of the American Medical Association today challenged a recommendation by a Senate subcommittee on manpower that an over-all civilian authority should be established to enroll physicians for the armed services.

The committee, headed by Senator Claude Pepper, urged that a study be made to determine the number of doctors needed for civilian communities and that a census of medical men be taken.

"Had Senator Pepper's committee made inquiry, it would have discovered that the inventories proposed were made by the American Medical Association in 1940, and by the procurement and assignment service in 1941, and that studies are made week by week of the distribution of physicians in civilian communities," the Journal said.

"The procurement and assignment service was created by the President of the United States and charged with consideration of the task of meeting the needs for physicians of the armed forces, industry and civilian population.

"It has approached the problem scientifically, with accurate inventories of physicians available and needed with due regard for the health of all the United States.

"Actually, what has been done might . . . well serve as a model for the other activities of the War Manpower Commission."

The publication also scored a committee recommendation that no recruiting of doctors for the military forces be permitted until the civilian authority was created. The Journal said:

"The least that the Nation can do for those who offer their lives in combat is to provide them with the utmost that medicine can offer for the alleviation of the wounded and the prevention of unnecessary death."—Los Angeles Examiner, November 4.

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Medical Journal Denounces Kaiser and Senator Pepper

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The Journal defended the work of the procurement and assignment service for physicians, dentists and veterinarians in allocating medical personnel for military, industrial and civilian needs and accused Senator Claude Pepper (D., Fla.) of calling before a Senate hearing only such physicians and others who were dissatisfied with the procurement and assignment service.

Senator Pepper, charged by the Journal with conducting a "one-man inquisition," heads the Senate committee on education and labor now conducting hearings on the medical personnel situation.

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"The performance displayed in Senator Pepper's hearings," the editorial concluded, "is not likely to improve the morale of American medicine at the very time when it should be at its highest in the service of the war effort."—San Francisco News, November 10.

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Kaiser Asks Probe of Dr. Fishbein

New York, Nov. 14.—(INS.)—Henry J. Kaiser, industrial wizard, today took time out from breaking shipbuilding records to challenge the integrity of Dr. Morris Fishbein, secretary of the American Medical Association.

Demanding that members of the organization investigate the medical executive because of an editorial in the current issue of the Association's journal, Kaiser asked, "If they find Dr. Fishbein in his attack on my motives to be dishonest or unworthy to represent their ideals they should immediately request his resignation."

Kaiser's challenge was based on the editorial charge in the Journal that he and other industrialists "desired to maintain their individual empires without disturbances, regardless of the need of the armed forces for physicians."

The question of conscription status of company doctors was thrashed out at the November 6 Senate Committee hearing in which Dr. Sidney Garfield, Kaiser's medical chief, asserted that A.M.A. members in charge of procurement for the armed services were threatening to draft Kaiser's company doctors unless they ceased group health activities.—Stockton Record, November 14.

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Deferment of 3-A's Offered For War Work

Men With Dependents Given New Inducement to Leave Nonessential Employment

Washington, Nov. 5.—(AP.)—The selective service system is seeking to induce large numbers of men with dependents to shift from nonessential work to war-supporting occupations by offering them the prospect of longer deferment from the draft. . . . —San Francisco Examiner, November 6.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Fifth Annual Congress on Industrial Health

The fifth Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association, will be held Monday, Tuesday and Wednesday, January 11-13, 1943, at the Palmer House in Chicago. These meetings are open to physicians and others interested in industrial health. There is no registration fee. The preliminary program is as follows:

Monday, January 11—Opening Session, 9:45 A.M.

Papers

Report of the Council on Industrial Health.

The Physician and Industrial Mobilization.

Preventive Medicine in Industry.

Employee-Management Coöperation for Industrial Health.

Procurement and Training of Professional Personnel for Industrial Health Service.

Ocular Signs of Industrial Poisoning.

Program by Days: Major Divisions

COMMON INFECTIONS IN INDUSTRY

(Joint Presentation by the Council on Pharmacy and Chemistry and the Council on Industrial Health, American Medical Association.)

Monday—Evening Session, 6:30 o'clock

STATE SOCIETIES' DINNER AND ROUND TABLE

An informal dinner and round table discussion, intended primarily for the personnel of committees on industrial health in state and county medical societies, will be held. Subjects for discussion will be:

Local Organization for Industrial Health Services.

Recent Experiences in Postgraduate Industrial Medical Education.

Tuesday, January 12—Morning Session, 9 o'clock

Industrial Physical Examinations: Report of the Committee on Physical Examinations of the Council on Industrial Health, American Medical Association.

HEALTH PROBLEMS ASSOCIATED WITH THE CHANGING CHARACTER OF THE WORK FORCE

Tuesday—Afternoon Session, 2 o'clock

INDUSTRIAL MEDICAL PRACTICE AND THE EMERGENCY

Streamlining Industrial Medical Service

How to Get Along with Less Help.

Tuesday, January 12—Morning Session, 9:30 o'clock

SYMPOSIUM ON MEDICAL RELATIONS IN WORKMEN'S COMPENSATION

(Joint Presentation by the Bureau of Legal Medicine and Legislation and the Council on Industrial Health, American Medical Association.)

Tuesday—Afternoon Session, 2 o'clock

SYMPOSIUM ON REHABILITATION

(Jointly Sponsored by the Council on Physical Therapy and the Council on Industrial Health, American Medical Association.)

Wednesday, January 13—Morning Session, 10 o'clock

SYMPOSIUM ON NUTRITION IN INDUSTRY

(Jointly Sponsored by the Council on Foods and Nutri-

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

tion and the Council on Industrial Health, American Medical Association.)

Wednesday—Afternoon Session, 2:30 o'clock

A Conference on Industrial Health will be presented under the auspices of the Chicago Medical Society and the Illinois Manufacturers' Association, together with many additional local and state collaborating agencies.

Ninth Annual Postgraduate Assembly: C.M.E.

The Alumni Association of the College of Medical Evangelists, in Paulson Hall of White Memorial Hospital in Los Angeles, on Sunday, December 6, 1942, presented its Ninth Annual Postgraduate Course. Program follows:

Morning Session

- 9:00 a.m.—"Combined Chemo Therapy and Fever Therapy in Treatment of Syphilis."
H. Worley Kendall, M. D., Associate Director of Kettering Institute for Medical Research, Miami Valley Hospital, Dayton, Ohio. (Dr. Kendall's paper will be read by Fred B. Moor, M. D., Professor of Pharmacology and Therapeutics, College of Medical Evangelists School of Medicine, Los Angeles, Calif.)
- 9:30 a.m.—"Primary Coccidioidomycosis."
William A. Winn, M. D., Medical Director, Tulare-Kings Counties Tuberculosis Hospital, Springville, Calif.
- 10:00 a.m.—"The Causes of Hypertension."
Maj. William Dock (MC), Professor of Pathology, Cornell University Medical College, New York, N. Y. (On military leave.)
- 10:30 a.m.—"Management of Chemical Injuries of the Eye (Including War Gases)."
Harold F. Whalman, M. D., Clinical Professor of Ophthalmology, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

Recess

- 11:15 a.m.—"Principles of Differential Diagnosis."
Julius Bauer, M. D., Clinical Professor of Medicine, College of Medical Evangelists School of Medicine, Los Angeles, Calif.
- 11:45 a.m.—"Recent Advances in the Treatment of Pelvic Inflammatory Disease."
George E. Judd, M. D., Assistant Clinical Professor of Gynecology and Obstetrics, University of Southern California School of Medicine, Los Angeles, Calif.
- 12:15 p.m.—"The Physician and the Social Implications of the War."
Walter H. Brown, M. D., Professor of Public Health, University of California School of Medicine, San Francisco, Calif.

Afternoon Session

- 2:30 p.m.—"Differential Diagnosis of Chronic Sinusitis and Chronic Allergy."
Ben R. Dysart, M. D., Instructor in Surgery (Otolaryngology), University of Southern California School of Medicine, Los Angeles, Calif.
- 3:00 p.m.—"Office Management of the Diabetic Patient."
Howard F. West, M. D., Clinical Professor of Medicine, University of Southern California School of Medicine, Los Angeles, Calif.
- 3:30 p.m.—"Lessons in Fracture Surgery from Recent War Casualties."
Comdr. Rudolph Joldersma (MC), Chief of Orthopedic Service, U. S. Naval Hospital, San Diego, Calif.

Recess

- 4:15 p.m.—"Manipulative Therapy for Back Injuries."
Horace C. Pitkin, M. D., Consulting Orthopedic Surgeon, Stanislaus County and St. Francis Hospitals, San Francisco, Calif.
- 4:45 p.m.—"Intravenous Urography."
Jay J. Crane, M. D., Associate Clinical Professor of Surgery (Urology), University of Southern California School of Medicine, Los Angeles, Calif.
- 5:15 p.m.—"Hypothyroidism."
E. Kost Shelton, M. D., Associate Professor of Medicine, University of Southern California School of Medicine, Los Angeles, Calif.

Evening Session

- 7:00 p.m.—"Physical in Contrast to Psychic Treatment of Certain 'Psychiatric' Disorders."
Johannes M. Nielson, M. D., Associate Clinical Pro-

fessor of Neurology and Psychiatry, University of Southern California School of Medicine, Los Angeles, Calif.

- 7:30 p.m.—"Practical Aspects of the Diagnosis of Breast Tumors."

Isaac Y. Olch, M. D., Assistant Clinical Professor of Surgery, University of Southern California School of Medicine, Los Angeles, Calif.

- 8:00 p.m.—"Determining Factors in Prognosis and Treatment of Mammary Carcinoma."

Ian J. Macdonald, M. D., Instructor in Surgery, University of Southern California School of Medicine, Los Angeles, Calif.

- 8:30 p.m.—"Certain Aspects of Sulfonamide Therapy."

Frederick J. Moore, M. D., Instructor in Bacteriology, University of Southern California School of Medicine, Los Angeles, Calif.

Registration Fee \$2.00.

No registration fee will be required of students, interns or residents.

COMMITTEE ON MEDICAL EDUCATION

Peril to Supply of Doctors Seen

Unless provision is made to assure a minimum of two years' premedical education," only women and the physically unfit" will be able to enter medical schools next year. Brig. Gen. Charles C. Hillman, surgeon general of the army, on November 20th, told army, navy, and civilian doctors attending the annual conference of Secretaries and Editors of Constituent State Medical Associations at 535 North Dearborn Street.

Gen. Hillman explained the lowering of the draft age to 18 is taking men who normally would enroll in medical courses next year. He expressed hope that plans will be made to assure a continuous supply of new physicians for essential industries and civilian communities.

Despite this future threat to medicine, speakers agreed the medical profession has supplied the armed forces with all the doctors required so far, and there still are enough left to assure civilians adequate medical attention. There is no likelihood of a shortage of doctors for the present, they said.

Dr. Frank H. Lahey, chairman of the board of procurement and assignment service for doctors, said the armed forces now have 6.5 doctors for every 1,000 men, and there is one doctor for every 1,500 civilians.

"The ratio of doctors to civilians in America is much higher than it is in other countries," he said. "England now has only one doctor for every 2,700 civilians, and Germany is functioning with only one for every 12,000 civilians. The procurement service has surveyed the entire nation and is now sending doctors to areas reporting a shortage. So far we have dispatched 218 doctors to 154 communities in 29 different states."

Discussing the rôle the Public Health Service has played during the war emergency, Dr. Thomas Parran, surgeon general of the service, said that medical officers and sanitary engineers are being moved to spots where the shift of population into the war industry areas has created a health menace.

Dr. Parran also announced that quarantine hospitals for civilian carriers of venereal diseases are being set up. The Wesley Memorial hospital will handle Chicago cases, he said. At these quarantine centers all disease carriers will be isolated in an effort to protect men in the services.

Medical Students Might Graduate in Five Years

Chicago, Nov. 13—(INS.)—Suggestions for turning out graduate medical students five years after high

school were advanced in the Journal of the American Medical Association here as one way of increasing the number of physicians needed in the war effort.

The recommendations were adopted by the association's council on medical education and hospitals and would provide for "granting the M. D. degree within a period of five years after graduation from high school as contrasted with seven to eight years before the war."

Under the plan, required premedical education would be squeezed into two calendar years, the premedical course would be a qualifying year for the medical course and matriculated students would be recommended for enlistment or commission in the army or navy and remain on an inactive list until graduation.—*Pomona Progress-Bulletin*, November 13.

Sulfa Poisoning Being Overcome in Experiments

*Advance in Fighting Effects Reported by
U. S. Health Service*

Washington, Nov. 22—(N.A.N.A.)—A possible long step forward in combating poisonous effects of sulfa drugs is seen in experiments just reported by the U. S. Public Health Service.

Perhaps the worst effect thus far reported is the development of the anemic condition known as agranulocytosis, or destruction of some types of white cells in the blood. A few years ago there was a national scandal when it was found that this was being caused by certain popular headache remedies. Victims almost always died.

But the agranulocytosis caused by sulfa drugs, apparently only in highly-susceptible individuals, can be stopped if treated in time, and thus far there have been no fatalities.

Doctors Clear Up Situation

Working to clear up the situation, Drs. S. S. Spicer, Floyd S. Daft, L. L. Ashburn and W. H. Sebrell, of the Public Health Service staff, fed rats with a scientifically adequate diet to which were added heavy doses daily of sulfaguanidine and a type of sulfathiazol.

For a few days there were no notable effects. Then the rate of growth of the young animals slowed down and soon growth stopped altogether. Agranulocytosis was produced with regularity, together with fragility of the blood vessel walls, several other serious blood conditions and a curious breaking out on the skin. The animals always died in a short time.

But, the Public Health Service doctors found they could prevent the agranulocytosis, other blood conditions and stoppage of growth entirely if they fed the animals, simultaneously with the sulfa drugs, regular doses of liver extract. The skin condition could be prevented entirely if they fed infinitesimally minute amounts of the B vitamin, biotin, most powerful of all physiological substances.

Mechanism Still Vague

The mechanism of the reactions is still vague, the physicians report. There is a possibility, they believe, that the sulfa drugs, given in heavy doses, prevent the synthesis within the body itself of certain essential vitamins, some of which may still be unknown. It is possible that the biotin is synthesized in this way.

There is also the possibility that the drugs act as a direct poison on certain blood cells, and that this poison is counteracted by something in liver extract. It is also possible that the sulfa substances interfere with one or more of the extremely complex enzyme systems of the animal body which are basic in the phenomenon of growth.—*Press Dispatch*, November 20.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (29)

Alameda County (6)

Elizabeth Torrey Andrews, *Berkeley*
Clarence B. Foltz, *Oakland*
Roger W. Hackley, *Oakland*
C. B. Hills, *Berkeley*
Glenn A. Pope, *Oakland*
James A. Stark, *Oakland*

Fresno County (1)

John Francis Murray, *Fresno*

Inyo-Mono County (1)

Charles W. Anderson, *Bishop*

Sacramento County (3)

Charles E. Anzinger, *Sacramento*
George L. Browning, *Sacramento*
Henry E. Kleinsorge, *Sacramento*

San Bernardino County (1)

Joseph Perlson, *Palton*

San Diego County (2)

J. L. Barritt, *La Jolla*
Alfred C. Dick, *La Jolla*

San Francisco County (9)

Fred Cassius Blake, *San Francisco*
Julian Stanley Davis, *San Francisco*
Malcolm H. Finley, *San Francisco*
Vincent H. Greco, *San Francisco*
Fred Bernard Marasco, *San Francisco*
Thomas Tanton Nickels, *San Francisco*
Roland D. Pinkham, *San Francisco*
Otto E. L. Schmidt, *San Francisco*
John Francis Skelly, *San Francisco*

Santa Barbara County (2)

Hugh E. Stephens, *Santa Barbara*
William Gordon Winter, *Santa Barbara*

Santa Clara County (1)

Edward C. Sewall, *Palo Alto*

Shasta County (3)

William Lisle Bell, *Redding*
Maurice Leopold Lubin, *Weaverville*
Harry Raymond McVicker, *Redding*

Associate Members (1)

John B. Saunders, *San Francisco*

Transfers (2)

Egil Hanssen, from Fresno County to San Bernardino County
Richard D. Loewenberg, from San Francisco County to Lassen-Plumas-Modoc County

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Billingsley, Urban Clark. Died at Gold Run, November 15, 1942, age 67. Graduate of Cooper Medical College, San Francisco, 1904. Licensed in California in 1904. Doctor Billingsley was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Eder, Lawrence Frank. Died at Santa Barbara, October 11, 1942, age 42. Graduate of the University of Minnesota Medical School, Minneapolis, 1924. Licensed in California in 1928. Doctor Eder was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

Ellis, Bertrand Le Roy. Died at Long Beach, October 31, 1942, age 30. Graduate of the College of Medical Evangelists, Loma Linda, 1940. Licensed in California in 1940. Doctor Ellis was a member of the Los Angeles County Medical Association, and the California Medical Association.

✱

Franklin, Edward Alfred. Died at Los Angeles, November 4, 1942, age 58. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1905. Licensed in California in 1921. Doctor Franklin was a member of the Los Angeles County Medical Association, and the California Medical Association.

✱

Gundrum, Frederick F. Died at Sacramento, October 23, 1942, age 62. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1908. Licensed in California in 1910. Doctor Gundrum was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✱

Heylman, Harry H. Died at Long Beach, October 30, 1942, age 74. Graduate of Kansas City Medical College, 1897. Licensed in California in 1915. Doctor Heylman was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

Liljencrantz, Eric. (Commander, M.C., U.S.N.) Died at Pensacola, Florida, November 5, 1942, age 40. Graduate of Stanford University School of Medicine, 1929. Licensed in California in 1929. Doctor Liljencrantz was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✱

OBITUARIES

Ellis Harbert

1866—1942

On July 16, Dr. Ellis Harbert, one of the veterans of the San Joaquin County Medical Society, passed on to his final reward. He had been ill for over six years and totally incapacitated for many months preceding his death, which was caused by biliary cerrihosis with complications.

Dr. Harbert was born in Green Forest, Arkansas, on January 12, 1866, and his early education was in the elementary schools of his home town and at the private academy in Little Rock, Arkansas, where he prepared for Vanderbilt University School of Medicine from which he was graduated in 1893. After some postgraduate study in New York, Dr. Harbert came to California and located in 1897, at Waterford, remaining one year. In 1898 he opened offices in Stockton, and for short periods had as associates Dr. Daniel F. Ray and later Dr. James P. Hull. There were no hospitals in Stockton in 1898, and the kitchen table was used for operating. Partly due to Dr. Harbert's urgent requests Reverend Father O'Connor built the hospital, since known as St. Joseph's,

and for the nearly forty years of his active practice, Dr. Harbert served on its staff.

For over twenty years Dr. Harbert was a member of the Stockton State Hospital Board. He was a great lover of the outdoors and duck hunting was his favorite sport. For indoor recreation he greatly enjoyed a guessing contest with his friends as to the value of the down card. In politics he was an ardent Democrat, and in religion was a liberal and one of the founders of the first Unitarian society in Stockton.

In his professional career, Dr. Harbert was primarily interested in surgery and through the years did a great volume of work and won the respect, confidence, and friendship of thousands. During the first World War when the Holt Manufacturing Company was the leading industry of this city, employing several thousand men, he was the company surgeon in addition to his large private practice. During the last years of his life when illness prevented active practice, Dr. Harbert utilized the trained skill of fingers in turning to wood carving, weaving, and other types of handiwork which he did with unusual skill.

The members of the San Joaquin County Medical Society extend their sincere sympathy to the surviving widow and daughter of their late esteemed and respected member.

DEWEY R. POWELL, M. D.

✱

Frederick F. Gundrum

1880—1942

Frederick F. Gundrum died at Sacramento, California, on October 23, 1942. Doctor Gundrum graduated from the Johns Hopkins University School of Medicine, Baltimore, in 1908, and was demonstrator in anatomy at the University of Pittsburgh in 1909-1910. He was certified as a specialist by the American Board of Internal Medicine; was a Fellow of the American College of Physicians. Dr. Gundrum was president of the California Academy of Medicine in 1937, vice-president of the State Board of Medical Examiners from 1913 to 1915 and of the California State Board of Health from 1915 to 1932. He was a valued member of the Sacramento Society for Medical Improvement, as well as past president and secretary of that Society. He served as chairman of the medical advisory board No. 7 during World War I; was director of the North California Branch of the State Laboratory from 1912 to 1915, and also chief visiting physician at the Sacramento County Hospital from 1910 to 1919, and secretary and member of the board of trustees of the Sutter Hospital.

During his years of practice in the Sacramento Valley, Doctor Gundrum made for himself a place in the hearts of patients, colleagues and fellow citizens—a place that will be hard to fill.

✱

Alfred Baker Spalding

1874—1942

Alfred Baker Spalding, 68, emeritus professor of gynecology and obstetrics in the School of Medicine of Stanford University, died at his San Francisco home Friday, Nov. 27. Dr. Spalding was widely known for the Spalding rule for the period of pregnancy, and for founding the San Francisco Home Maternity Service for persons of limited means. In failing health for some years, Dr. Spalding became emeritus from Stanford in 1930, and retired from active practice eight years ago.

He was one of Stanford's football immortals, playing with the team that was coached by Walter Camp and managed by Herbert Hoover. Following his graduation from Stanford University in 1896, he attended Columbia University which awarded him the M. D. degree in 1900.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM...Asst. Chairman on Publicity

News Items

In spite of the imminent gas rationing and tire shortage, Alameda County members are still responding one hundred per cent to the one day a month hospitality center service for men in the armed forces.

Three weeks in October were devoted to a letter campaign in support of the Basic Science Act. Although the Act was defeated, it is hoped that the ground work has been laid for a favorable return the next time it appears on the ballot.

Entertainment at the regular November meeting of the Auxiliary was furnished by Mrs. William H. Sargent, who sang a group of songs. Ena Louise Spencer, balloonist and parachutist, of London, England, talked about "England Under Fire."

Mrs. Floyd Bell, President, has announced that there will be no December meeting.

"Medical Morale" is the theme adopted for this year by the Woman's Auxiliary to the Los Angeles County Medical Association, and with this in mind, the opening business meeting was held on Tuesday, October 27, at 12:30, at the Chapman Park Hotel with Mrs. Franklin Farman, President, presiding.

Mr. Richard Atkinson, world traveler, author and member of the American Press Commission to Europe, gave a most interesting talk on "Russia and the World Today."

Honored guests were officers of the Los Angeles County Medical Association, namely: Dr. George D. Wells, President; Dr. Robert W. Wilcox, Vice-President, and Dr. Louis A. Alesen, Secretary and Treasurer.

Mrs. William R. Molony, Jr., Legislative Chairman, spoke briefly and introduced Mr. Ben Reed, Executive Secretary of the Public Health League of California, and Mr. Stanley Cochems, Executive Secretary of the Los Angeles County Medical Association. Mr. Reed spoke in behalf of Proposition No. 3, and Dr. Alesen lead a discussion and answered questions from the floor.

Mrs. Newell Jones, Chairman of Philanthropy, announced that Auxiliary members are to sell tickets for a drawing on March 23, 1943, on a \$100 00 Defense Bond. This will be for the benefit of the Philanthropy Fund.

There is to be a District meeting held in Santa Ana on Friday, November 13, at which this Auxiliary will be represented.

A meeting of the Riverside Auxiliary was held on October 12th, at the Riverside Community Hospital. Mrs. Erwin Miller, program chairman, presided.

There were 12 members present and the evening was spent in rolling bandages for the hospital.

An appeal for help at the U.S.O. house was voiced by Mrs. H. J. Wickman. Mrs. H. W. Naockel asked for donations of used furniture for the Red Cross hospitals and recreation committees.

Plans for the distribution of information in regard to the Basic Science Act were discussed.

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Members of the Woman's Auxiliary to the Sacramento County Society for Medical Improvement were hostesses to the Eighth District at a luncheon, held at the Senator Hotel, on November 5th, at 12:45 p.m. Mrs. Manuel L. Azevedo, the newly-elected President of the Society, greeted the out-of-town guests.

Mrs. Charles Landis, of Chico, Councilor of the Eighth District of the Woman's Auxiliary to the California Medical Association, Mrs. F. G. Lindemulder of San Diego, State President of the Auxiliary, and Mrs. Ralph Eusdon, First Vice-President, were among the out-of-town guests who were entertained. Mrs. Landis presided.

The flower decorations were carried out in a Harvest theme, these being arranged by the Chairman of the Decorations Committee, Mrs. Lorenz Ruddy.

The members and new guests of the Society were greeted by the Hostesses Committee, under its Chairman, Mrs. J. Vincent Crawley, assisted by Mrs. Dan O. Kilroy.

The Woman's Auxiliary to the Humboldt County Medical Association met at the home of Mrs. Louis Weichselfelder, on Monday, November 2, 1942, at 8 o'clock p.m.

The meeting was called to order by the Vice-President, Mrs. B. M. Marshall.

It was decided that no meeting would be held in December, the next meeting to be at the home of Mrs. Joseph F. Walsh, on the afternoon of January 14, 1943. This meeting will be followed by a Tea to be given in honor of the visiting Navy and Army Medical wives and for the family members of the local Auxiliary. Mrs. Orris Myers was appointed as General Chairman for the occasion, with Mrs. John S. Chain, Jr., acting as her assistant. One of the duties of these two members will be to contact all Navy and Army Medical wives.

On December 7 to 14, inclusive, members of the Auxiliary will take turns as hostesses at the local U.S.O. Center.

Mrs. Walter Dolfini, Treasurer, has been authorized to turn over the proceeds collected from the two play readings, given by Mrs. Gordan Manary last spring, to the local Red Cross.

The Woman's Auxiliary to the Marin County Medical Society held its second meeting of the year, on October 22nd, at the Blue Rock Hotel, in Larkspur.

Following dinner, Mrs. Harry O. Hund introduced Dr. Isabelle Lewis Main, who told of the remarkable things that had been done in the past for the Chinese and the great need for food and medical care that now existed. Dr. Main spoke in behalf of the China War Relief. The members of the Auxiliary contributed generously to the cause and also voted to take money from the treasury to donate to the drive.

The business meeting was held following the program. Mrs. Rodney B. Hartman, presiding. It was announced that Mrs. Lindemulder, State President, would be in Santa Rosa, November 4th, to meet with the Auxiliaries of Sonoma, Solano, Marin and Medocino-Lake Counties.

Dr. John Cline, President of the San Francisco County Medical Society, addressed the Woman's Auxiliary at their October meeting. Dr. Cline spoke on the importance of passing the Basic Science Act.

Dr. Maurice L. Tainter, Professor of Pharmacology at the Stanford Medical School, discussed the "Revolution in treatment caused by Sulfanilamide"

About 65 members heard the speakers and attended the

business meeting which followed. Mrs. Raleigh Burlingame, President, presided. Mrs. Norman Morgan, Hospitality Chairman, who arranged the Tea, was assisted by Mrs. Thomas Gibson, Mrs. William Reilly, and Mrs. Paul Wyne.

One of the projects of the Auxiliary this year is assisting at the San Francisco County Medical Society's Blood Bank. Mrs. Howard Dixon is Chairman of the Motor Corps; Mrs. Guy Schoonmaker, Canteen; Mrs. Roger McKenzie, Technician's Aides. These departments are all staffed by Auxiliary members.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Industrial (September).....	37,871
Rural Health Program	1,500
War Housing Projects (December 1st)	
(Approximate)	6,500
Vallejo	2,000
Marin	3,200
San Diego	1,500

C.P.S. has recently signed contracts with the Housing Authorities of Marin County, Vallejo and Los Angeles. These authorities are providing housing to bona fide war workers. The estimated population to be covered under the medical and hospital plan will be approximately 100,000 persons. This is a tremendous responsibility for the medical profession of California. A good job must be done. *Every physician in California is committed to help make this a success.*

There are far-reaching implications in this endeavor in which governmental agencies have turned over and have given to a state-wide organization of the medical profession the opportunity to do its part in the war effort. *Failure* can only mean that some one else must do the job—and that can only mean the government. *Success* will mean satisfaction in having made a valuable contribution to war production, plus an unpredictable advantage in leadership in the field of medical economics for the population as a whole.

* * *

JUST A FEW THINGS TO THINK ABOUT

Who will provide the medical care for:

250 000 war workers in California now, and the x number, 6 months from now?

The 150 000 migrating within the state?

Continuous westward migration of labor of all kinds?
New cities being built by Federal Public Housing Authority without regard to supply of physicians or hospital facilities?

Metropolitan population increasing rapidly?

When it is known that:

California's quota to armed forces remains the same.
Many rural communities are already without enough physicians.

Many metropolitan practices stretched to the breaking point.

Resident population getting jittery.

New housing projects with no medical facilities whatsoever.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization. For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

Shall it be:

Readjustments on an individual basis?

War Manpower Commission?

National Housing Agency?

United States Public Health Service?

Legislation?

or

OURSELVES?

A. E. LARSEN, M. D.,

Secretary-Medical Director.

* * *

CALIFORNIA PHYSICIANS' SERVICE

153 Kearny Street

San Francisco, California

BULLETIN OF OCTOBER 30, 1942

Financial operations for the month of August were as follows:

Dues collected	\$51,663.74
Late dues and unused portion of prior allocations	308.11
Professional member dues	65.00
	<hr/>
	52 036.85
Cost of Administration.....	9 779.52
Available for August business.....	42 257.33
	<hr/>
Available for remaining professional services	39 314.38
X-ray and lab. on hospitalized patients.....	2 942.95
	<hr/>
29,807.8 units of service.....	38 750.14
	<hr/>
Transferred to Unit Stabilization Fund....	564.24
Previous balance in Fund.....	24 611.69
	<hr/>
Total Unit Stabilization Fund.....	\$25,175.93

* * *

BULLETIN OF DECEMBER 1, 1942

Financial operations for the month of September were as follows:

Dues collected	\$49,365.51
Late dues and unused portion of prior allocations	738.88
Professional member dues.....	105.00
	<hr/>
	50 209.39
Cost of Administration.....	12 202.18
	<hr/>
Available for September business.....	38 007.21
X-ray and lab. on hospitalized patients.....	2 584.68
	<hr/>
Available for remaining professional services.	35 422.53
25,645.1 units of service.....	35 903.14
	<hr/>
Transferred from Unit Stabilization Fund..	480.61
Previous balance in Fund.....	25,175.91
	<hr/>
Total Unit Stabilization Fund.....	\$24,695.32

* * *

One Wartime Medical Care Problem Solved by the Medical Profession Itself: Some Excerpts from FPHA Bulletin, Published by Federal Public Housing Authority, Washington, D. C., No. 19, of November 10, 1942

"A prepaid medical service plan for war housing tenants is in operation at the Marin City project of the Marin County Housing Authority in California. The plan includes complete medical care, surgery, and hospitalization furnished by agreement with the California Physicians' Service, a nonprofit organization which op-

crates a state-wide prepayment medical service sponsored by the California State Medical Association.

"Membership in the plan is voluntary on the part of tenants. . . . There has been enthusiastic response from the Marin City project tenants. Thus far 600 families and 1,100 single men already living there have joined the plan. Tenants pay a monthly fee of \$5 per family with children, \$4 for a two-person family, and \$2.50 for a single person.

"The plan grew out of the wartime necessity to assure medical care for in-migrant war workers and their families. Not only have those families been cut off from family physicians in their former communities, but the induction of doctors into military service has curtailed medical services in the communities in which they are now living. A further factor is the necessity to supply medical services which will help to prevent the spread of contagious diseases among highly concentrated populations in war production areas.

"Authorities in other California cities and towns are eager to participate in the plan and procedures for their inclusion are being prepared. Coöperating with FPHA and local housing authorities is the United States Public Health Service. All three have combined responsibility in arranging medical care for families living in public housing projects.

"The plan includes a medical center in the project, supplied with proper medical and nonmedical equipment, and staffed by nurses and resident physicians."

A. E. LARSEN, M. D.,
Secretary-Medical Director.

Housing Project Renters to Get Free Medical Care

Vallejo, Nov. 16.—Complete medical care as a routine service included in the weekly rent bill will be offered starting today to 800 Mare Island Navy Yard workers and their families living in Vallejo's Victory Apartments in an experiment which may show the nation how to solve the health problem in over-crowded defense plant areas.

The service, if it proves itself, will be extended to the 10 to 12 thousand persons soon to occupy Chabot Terrace and later to Federal Terrace, Lincoln Highway dormitories, and other Federal housing projects under jurisdiction of the Vallejo Housing Authority.

The Vallejo undertaking, with a similar experiment under way with 4,000 residents of Marin City at Richmond, will be under the scrutiny of Government experts charged with protecting millions of defense workers from war-born pestilence.

The nearly 3,000 workers, wives and children in Victory Apartments, located west of Fourth Street from Rayland Street to the Southern Pacific tracks, will have every medical service, including 21 days of hospitalization at their disposal for the asking. Utilization of the service will be optional and doctors in charge will coöperate to the fullest extent with physicians of the Solano County Medical Association and Vallejo Academy of Medicine who are in large part responsible for the experiment.

Offices, staffed by doctors and nurses assigned by the Doctors Procurement and Assignment Service of the War Manpower Commission, will be opened at 516 Ryder Street. Dr. Albert E. Larsen, medical director of the California Physicians' Service, which will handle the project, said the office would be opened today.

This announcement was made after a conference with Maurice Wilsie, executive manager of the Vallejo Housing Authority, Dr. E. R. Mills of the district office in San Francisco, Dr. M. A. Dexter of the Solano County Medical Association, John A. Bohn, executive manager of Chabot Terrace, and Larry Wise, head of the Vallejo Housing Authority department of project services.—*Oakland Tribune*, November 16.

Workers to Pay Medics with Rent

San Francisco (INS.)—Several thousand families in California war-plant industrial communities now pay their doctor bills in advance, and with their rent. And within a few weeks 35,000 California farm families will be adopting a similar prepayment plan which last year reduced farm medical costs in three experimental counties to between \$10 and \$20 a year per person.

The urban coördination of rental and medical charges has been inaugurated in Sausalito, San Diego and other cities which have large housing projects for war workers. The housing authority turns the money for medical service over to the California Physicians' Service, which assigns doctors and nurses and maintains clinics.

These innovations are only two of many which war conditions are effecting in medical and hospital practice in Pacific Coast states now coping with a double threat to public health—sudden boom town gains in population and the loss of a high percentage of young physicians and surgeons to the armed services.

Deduct Charges

Some of the big-scale employers—notably Henry J. Kaiser—have elaborated and extended the system of deducting charges for medical check-ups from the wages of their workers.

Executives of crowded hospitals are refusing to accept patients who can be treated in their own or nursing homes.

Hard-pressed physicians and surgeons are discussing establishment of district medical centers. These would eliminate many medical calls at private homes. Only the seriously ill who were also bedridden would receive such calls. Other patients would have to go to the doctors at the nearest medical center.

Facing the virtual certainty that the coming winter months will increase the incidence of colds, pneumonia and influenza, clubs and civic organizations are sponsoring public instruction in standard methods of health protection and home nursing.

While these steps are being taken to reduce disease hazards in the cities and towns, a new program to extend adequate medical service to the low-income group of California farmers will become effective shortly. Under its provisions, as announced by the farm security administration and the California Physicians' Service, any farm family with a net yearly income of \$2,000 or less may join the coöperative group. About 35,000 families, or 130,000 persons, are being offered membership.—*San Jose News*, November 11.

Health Aid to Low Income Farm Groups

Group Action Follows Forming Associations Program to Benefit

Benefits of the rural health insurance program offered by the California Physicians' Service are open to families whose incomes are at least 50 per cent from agricultural sources and the net of which as reported for 1941 State income tax did not exceed \$2,000, upon certain group action by a sufficient number of these families in any given locality. Coverage does not actually begin until membership cards are received by the family members from the physicians' service.

The group action involves the formation of a farmers' health association which enters with the physicians' service into a contract known as "The Rural Health Service Agreement." A constitution and by-laws to govern the association are drawn up by the organizing committee, acting as a temporary board of directors. Each family applying for membership, signs on the application a pledge to abide by this constitution and by-laws.

Membership Dues

Membership dues for participation in the insurance program, plus a small amount for the running expenses of the local association, are payable by check or money order made in favor of the California Physicians' Service and held by a trustee until the close of the period for receiving dues, at which time they are sent as one fund from the farmers' health association to the physicians' service headquarters, at 153 Kearny Street, San Francisco. There the physicians' service acts as a trustee for its physician members, paying them monthly on a unit basis for the services they report as having rendered the previous month to participants in the insurance program. The portion of the fund that represents dues for running expenses of the local association is returned to the treasurer of the association.

List Members

Accompanying the fund which is sent from the farmers' health association to the physicians' service are the applications for membership and a list of the families whose applications and dues are included. The applications, containing the names of members of each family, are used for making the membership cards for each person in families whose applications are approved. The name of any family whose eligibility is questioned by the local organizing committee or local physicians' reviewing board is starred on the list, and the physicians' service may request that family for a copy of their 1941 income tax

report or for other information to determine their eligibility.

The presentation of the individual membership card to the physician at the time he renders services included under the coverage of the insurance program authorizes him to send his bill, in the form of a statement of services rendered, to the physicians' service instead of to the family.—*Madera Tribune and Mercury*, October 26.

Health Insurance

Medical Care Included in Federal Rent

"Now," said the rental agent, "here is a lovely apartment—plenty of room for you and your family, completely furnished, and the rent is only \$45 a month—including complete medical and hospital care in case of illness."

Here is modern health insurance—doctor bills paid in advance, as part of the rent.

It is already in effect for 8,000 California war workers in Federal war housing projects, and will eventually spread to an estimated 100,000 or more.

Contracts Revealed

Its development was revealed here yesterday by Dr. A. E. Larsen of California Physicians' Service, following completion of contracts in four war centers.

The first district takes in thousands of airplane workers in San Diego, the second covers all Marin county, including Marinship and Hamilton Field, the third involves shipbuilders and aircraft workers in Los Angeles, and the fourth takes in 1,000 families in the Vallejo district.

"The San Diego project was our guinea pig," Dr. Larsen said, "We actually were planning it before the war, and signed the contract this May. That's where we learned our lessons."

In each case, the agreements were made by C.P.S. and local physicians' groups with the Federal Public Housing Authority and the local housing authority.

The cost of protection is \$2.50 a month for a single worker, \$4 for a man and wife, and \$5 for a man, wife and family.

Only those living in war housing projects are entitled to this type of coverage, although other C.P.S. contracts have been made recently with industrial and agricultural groups.

Doctors Collected

The medical contracts for residents of war housing projects provide complete medical and hospital protection with only two limitations—no more than 21 days' hospitalization for any single illness, and no more than \$5 per day for hospitalization in maternity cases.

Patients with minor illnesses are treated in the clinic provided at each housing project. If their illness is serious, they are advised to consult a private doctor of their own choice, or—if they have one—their family doctor in the neighborhood.

To staff the clinics, Dr. Larsen said, it has been necessary to hire local men where available or bring outside doctors into war-booming communities.

Many doctors have been "collected" from ghost towns, where nearly all the residents have gone away to the shinnards, and brought to Vallejo, Sausalito or Los Angeles.

Alien physicians, unable to secure commissions in the Army or Navy Medical Corps, have been given vital jobs in caring for war workers.

Morale Builder

Some of these newly recruited men are giving full time to their patients in housing projects, while others are spending part time on them and part time on their private patients.

Dr. Larsen declared the new arrangement has aided in building morale, decreasing lost time due to illness, and sparing workers from the shock of the cost of sudden illness.

"This is not State medicine," he said. "It merely shows that the medical profession has found a way of working with the Government."—*San Francisco Chronicle*, December 11.

The Doctor's Bill.—An editorial appeared some time ago in *America* in which a survey by the Metropolitan Life Insurance was quoted and which showed that the average annual payment for the average family to its physicians is \$140.00. The figure may be accurate but it gives no hint to the usual long delays after the service was rendered before payment was made. The commentator makes the following remarks.

"Now the cost of repairing the human machine engenders one of the most interesting problems of the day. It is a most important factor in the family budget. From very many parts of the country the report has come that, after the bill for medical services has been rendered, the family physician, who floated into the house with healing upon his angelic wings, assumes the menacing part of a Shylock.

"That medical, hospital, and surgical fees do impose a terrific burden upon some families is beyond all question. To many a man working for a salary, the physician's order to go to a hospital for an operation, is worse than a decree in bankruptcy. It means, in many instances, the loss of his job, and a period in which bills pile up so high that he must work for the rest of his life to pay them.

"This fact is recognized by the profession. For several years medical, surgical and hospital committees have been surveying the field, and as they are animated by an honest purpose, we can rely upon an accurate and intelligent diagnosis of a very serious social problem. But it has already become apparent that the reason of many a heavy hospital bill is the fact that the patient and his family have demanded unnecessary, and even luxurious, accommodations, and special service. Even when they are sick, some people never lose their ambition to keep up with the family of Jones.

"One aspect of this problem should not be lost sight of. If some physicians demand, and collect, exorbitant fees, others never receive the modest fees which they ask. Every profession has its list of nonpaying clients, but the physicians probably have the longest catalogue. Men who have been snatched from Mr. Toots would designate as the Cold and Silent Tomb, are so jubilant that they are quite unable to think of anything so prosaic as a bill for professional services rendered. Besides, now that the crisis is safely passed, they are too busy arranging a vacation trip.

Medical and Hospitalization Benefits for Veterans of World War II.—S. 2726, introduced by Senator Clark, Missouri, August 20, and pending in the Senate Committee on Finance. A bill to amend Section 6 of Public Law No. 2, Seventy-third Congress, March 20, 1933, as amended.

Comment.—The purpose of this bill is to accord to the veterans of the present war the medical and hospitalization benefits made available to veterans of World War I.

"On the Side."—A paragraph from the Column of E. V. Durling:

Queries from clients. Question.—I would like to ask you a fair question: If a doctor is doctoring a doctor, does the doctor doing the doctoring, doctor the doctor the way the doctor being doctored wants to be doctored or does the doctor doctoring the doctor doctor the doctor the way he usually doctors?

Answer.—As I understand it the doctor doctors the doctor the way he thinks the doctor should be doctored, but while the doctor doing the doctoring is doctoring the doctor, the doctor being doctored demands that the doctor doctor him the way he, the doctor who is being doctored demands. The doctor doing the doctoring and the doctor being doctored then get into an argument about the doctoring. This aggravates the doctor being doctored, and the doctoring done by the doctor doing the doctoring is of no avail. That is why doctors die younger than other people. I hope I make myself clear.—*San Francisco Examiner*, September 4.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Biltmore, Los Angeles. Sunday, May 2, 1943, and Monday, May 3, 1943.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a.m., under the title, "Your Doctor and You."

In December, KFAC will present these broadcasts on dates of December 5, 12, 19, and 26.

The Saturday broadcasts of KECA are given at 10:30 a.m., under the title, "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Pharmacological Items of Potential Interest to Clinicians*:

1. *New Books:* Some of Hans Zinsser's thoughtful poetry appears in his *Spring, Summer and Autumn*, just published by Little Brown. J. Needham edits an important series of essays on Comenius, "The Teacher of Nations" (Cambridge). W. N. East discusses "The Adolescent Criminal" (Churchill, London, 1942). C. D. Darlington reviews "Recent Advances in Cytology," and Churchill also issues an "Outline of Town and City Planning." Seventh edition of J. Glaister's "Medical Jurisprudence and Toxicology" appears (Livingstone, Edinburgh, 1942). R. A. Kilduffe and M. DeBaakey discuss the "Blood Bank and Technique and Therapeutics of Transfusion" (Mosby, St. Louis, 1942). G. A. Bennett, H. Waite and W. Bauer write on "Changes in Knee Joint at Various Ages" (Commonwealth, N. Y., 1942). J. S. Lundy offers a volume on "Clinical Anesthesia" (Saunders, Phila., 1942). R. A. Leonardo writes a "History of Gynecology," a "History of Surgery," and "An American Surgeon Abroad" (Froben, N. Y., 1942). A. A. Werner's "Endocrinology" (Kimpton, Lond., 1942), stresses relation of endocrines to Autonomic Nervous System. Second revision of Merck's, *Treatment of War Injury* is O.K.—ask for a copy.

2. *Nutrition:* Oleanders (like orchids), to F. J. Stare and Nutrition Foundation for issuing *Nutrition Reviews* (Vol. 1, No. 1, Nov., 1942). F. W. Quakenbush, et al (*J. Biol. Chem.*, 145:169, 1942), note that tocopherol prevents oxidation of carotene in oil solutions. P. Handler and W. Dean (*Ibid.*, p. 145), indicate that pellagra involves dysfunction of adrenal cortex. B. Wood, B. Splatt and I. Maxwell (*Med. J. Austral.*, 2:263, Sept. 19, 1942), observe that thiamine hastens emptying of stomach, but does not affect gastric secretion in man.

3. *Aviation Medicine:* Have you seen the remarkable "Compendium of Aviation Medicine," by S. Ruff and H. Strughold, with Introduction by E. Hippke, Chief of Medical Staff of German Air Corps, and translated and issued under license of the Alien Property Custodian? J. C. Stickney and E. J. Van Liere (*J. Avia. Med.*, 13:170, 1942), note that short exposures to low oxygen tension may produce some acclimatization. E. J. Van Liere and G. A. Emerson (*Ibid.*, p. 182), find that quinine, atabrine and plasmochin have no influence on lethal effects of anoxia.

4. *Cancer:* H. Blum, et al (*J. Nat. Cancer Inst.*, 3:83, 1942), make important survey of limits of accuracy in experimental carcinogenesis. A. Taylor, M. A. Pollack and R. J. Williams (*Science*, 96:322, Oct. 2, 1942), report that various types of malignancy tend to have similar cellular metabolism, forming a common tissue type. F. Dickens and H. Weil-Malherbe (Newcastle, Eng.), note possible carcinogenic activity of wood smoke (*Cancer Res.*, 2:680, 1942). Last June's Endocrine-Cancer Conference is reviewed in the October issue of *Cancer Research*.

5. *Infections:* H. C. Souza-Araujo (*Mcm. Inst. Oswaldo Cruz*, 37:95, 1942), offers evidence that certain

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School, Galveston, Texas.

species of ticks may transmit leprosy. *Med. Res. Council. Sp. Rep.*, 245, 1942, reviews ecology of bed-bug infestation and finds heavy naphtha best for control. B. Sjogren (*Nature*, 150:431, Oct. 10, 1942), says he's making naphthoquinone sulfonamids for chemotherapy of tuberculosis. L. Arnold (*J. Invest. Dermatol.*, 5:207, 1942), gives neat report on physico-chemical changes in cornified layer in relation to endogenous bacterial flora of skin, finding that alkaline moisture increases bacteria, while acid dryness decreases them. C. H. Rammelkamp (*War Med.*, 2:830, 1942), finds (like California dermatologists), that tyrothricin is useful in local staph and strept infections. An admirable item in geographical medicine is A. A. Moll and Mrs. S. O'Leary's series of reports on Plague in the Americas in recent issues of the *Bulletin of the Panamerican Sanitary Bureau*.

6. Notes: "Evans Blue" (T-1824), again is recommended for estimations of blood volume in man by L. J. Davis (*Edin. Med. J.*, 49:465, 1942), here's to Herbert! L. L. Miller and G. H. Whipple (*J. Exp. Med.*, 76:421, 1942), note that methionine protects against protein depleted susceptible liver injury from chloroform, even when given 3 hours after anesthesia. E. Rothlin (*Schweiz. Med. Woch.*, 71:1526, 1941), finds phosgene absorbed from lungs and that systemic poisoning may be antidoted by calcium and ergotamine.

Final Vote on Proposition No. 3 (Basic Science Initiative).—On page 335 of the November issue of CALIFORNIA AND WESTERN MEDICINE appeared a summary of the vote by California Counties on the Basic Science Initiative up to November 5, 1942. Reply to a letter sent to the Secretary of State on December 11th contained the information that the total vote on Proposition No. 3 (Basic Science Initiative) was: In favor of No. 3, 584,324. Against No. 3, 1,132,957. The measure was defeated by a total of 548,633 votes.

A.M.A. Court Decision to Get U. S. Supreme Court Review.—The Supreme Court on October 12th, agreed to review a decision holding the American Medical Association guilty of violating the Sherman Anti-trust Law by alleged activities against a group-health organization in the District of Columbia.

Granting of the Medical Association's petition meant that the tribunal would hear oral arguments in the case and then would deliver a formal opinion. Denial of a review leaves in effect the decision of the lower court.

The Medical Association, joined by an affiliate, the Medical Society of the District of Columbia, sought a review of an adverse decision by the United States Court of Appeals for the District of Columbia. This decision upheld a \$2500 fine against the National Association and a \$1500 fine against the local society.

The Association contended that practicing medicine was a profession, not a trade, and hence could not be prosecuted under the Sherman Act, which prohibits activities "in restraint of trade."

The medical organizations were accused of conspiring against Group Health Association, Inc., described as a nonprofit cooperative association of Government employees.

Gas Rationing.—The staff of the California Hospital, at Los Angeles, has issued a special bulletin on gas rationing for physicians. For the information of readers, excerpts follow:

"Most of these questions regarding gas rationing were

secured through the courtesy of C. W. Decker, M. D., in coöperation with the Automobile Club of Southern California. It is, therefore, issued for your information.

"**Gasoline Ration:** Your 'A' book represents 90 miles of so-called 'family driving,' i.e., to church, to the market, etc. All the balance of the 'A' book is for essential driving in professional service. The 'C' book covers strictly professional service driving only, with coupons for the stated mileage given by you in your application. Each ration book is computed upon a rate of 15 miles per gallon of gasoline.

"Few, if any cars, as they must be driven by the physician, with frequent stops and starts, can give 15 miles to the gallon efficiency. To obtain additional gas, Federal Regulations for gasoline rationing provides in Sec. 8053, that holders of the 'C' book finding their allowance not sufficient to travel the mileage stated in their application, may make application to their Ration Board for a supplemental allowance, in addition to that given by the 'A' and 'C' books.

"To qualify for such additional allowance, the Legal Department of the Automobile Club of Southern California advises:

"(a) Keep exact record of speedometer mileage, at beginning of ration period, having this verified by the proprietor of the service station supplying you with gasoline.

"(b) Record of mileage traveled, and sales slips showing number of gallons of gasoline consumed, in a 30-day period, with verification as in (a).

"(c) With this data, go to your Ration Board, obtain form for supplemental allowance of gasoline.

"The Board will give any other instruction required, that you may properly complete your application."

Dr. H. S. Rogers, Past President of C.M.A. is Cited for World War Injuries.—The following item appeared in the *Petaluma Argus-Courier*, November 9, 1942:

Dr. H. S. Rogers, World War I veteran and prominent local physician and surgeon, Saturday received from the quartermaster-general's office in Philadelphia upon order of the adjutant-general's office in Washington, D. C., the purple heart cross, citation for injuries received in action Sept. 26, 1918, in the Argonne forest on Vauqui hill.

The cross, struck in gold, has a bas-relief figure of George Washington in white on a purple field. On the reverse side is inscribed, "For meritorious army service."

In acknowledging receipt of the citation, Dr. Rogers pointed out that its arrival is timely with the celebration of Armistice day.

Urology Award.—The American Urological Association offers an annual award 'not to exceed \$500' for an essay (or essays) on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, May 31-June 3, 1943, Hotel Jefferson, St. Louis, Missouri.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 1, 1943.

California Board of Medical Examiners: Secretary Pinkham Will Retire.—Another veteran who plans to retire soon is Dr. Charles Pinkham, secretary of the State medical board for the past 30 years. He was re-elected for another term when the board held a three day meeting in Sacramento but indicated he would retire next February, when he reaches the mandatory age limit for leaving State service.* Dr. Percy Dolman, of San Francisco, was named president, succeeding Dr. Fred De Lappe of Modesto. The new vice-president of the board is Dr. George Thomason of Los Angeles.—*Vallejo Times-Herald*, October 29.

Comparative War Losses.—Here is a box score of the first year of war's toll of Japanese and American ships in the Pacific and the Far East, as announced by official United States communiques.

The list includes only ships announced as sunk, eliminating apparent duplications. Those probably sunk or damaged are omitted in this comparison because damage to American warships usually is not announced. Furthermore, many enemy ships announced as damaged undoubtedly have been repaired and put back in service, and the damage total probably includes several instances of a single ship being damaged several different times, with each occasion announced as damage to an enemy ship.

The box score of ships sunk:

	Japanese	U. S.
Battleships	3*	2†
Carriers	6	4
Cruisers	27	7
Destroyers	58†	22
Submarines	12	5
Plane tenders	1	1
Minesweepers	3	7
Transports	59	6
Tankers	20	3
Merchant ships, cargo, supply, etc....	80	13
Miscellaneous noncombatant	16	2
Miscellaneous warships	21	13
Total	306	85

Highlights of War

Washington, Dec. 1.—Highlights of a year of war:

Announced American Casualties

	Dead	Wounded	Missing	Prisoners	Total
Army	1,214	1,531	29,668	178	32,591
Navy	4,117	1,424	8,140	462	14,143
Marines	775	722	1,900	728	4,125
Coast Guard	37	11	126	...	174
Merchant Marine....	463	11	2,438	24	2,925
Total	6,606	3,688	42,272	1,392	53,958

Size of Armed Forces

	Dec. 7, 1941	Dec. 7, 1942
Army	1,800,000	4,800,000
Navy	325,000	1,100,000
Marines	60,000	210,000

War Production

	1941	1942
Aircraft (number)	14,000	49,000
Merchant Ships (tons).....	1,640,000	8,200,000

Pacific Shipping and Naval Losses

	U. S.	Japan
Naval Ships Sunk.....	61	131
Non-Combatant Ships Sunk.....	24	175

Battle of Western Atlantic

U. S., Allied and Neutral Ships Sunk.....	591
Axis Submarines Sunk.....	?

* One may have been a heavy cruiser; one was the *Haruna*, announced as sunk by the Army early in the Philippines campaign, but the claim since has been questioned.

† Two may have been cruisers.

‡ The *Arizona* and *Oklahoma*, sunk at Pearl Harbor, *Oklahoma* listed as sunk, since Navy has not yet decided whether to go ahead now with righting her and putting her back in commission.

The list includes American ships which were scuttled to keep them from being captured by the enemy as well as ships lost by accident.

—San Francisco *News*, December 7.

* Doctor Pinkham will retire as Secretary, but not as a member of the Board.

Radio Broadcasts: "Doctors at War."—American Medical Association dramatized radio broadcasts in co-operation with the National Broadcasting Company will be resumed Saturday, December 26, at 5 p.m. eastern time (4 o'clock central time, 3 o'clock mountain time, 2 o'clock Pacific time). The title of the new series will be "Doctors at War: Book III of Doctors at Work."

Doctors at War will be broadcast with the official approval and coöperation of the Medical Department, United States Army, and the Bureau of Medicine and Surgery, United States Navy. Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, will appear on the program on a selected date. The broadcasts will be a continuation of the story of Doctors at Work, carrying the fictitious but typical American physicians into the military and naval services of the United States and following the development of the practice of medicine in typical American communities affected by industrial expansion, troop programs and other wartime influences.

As in past years, the program will be dramatized. Scripts will again be written by William J. Murphy, continuity editor, central division, National Broadcasting Company. Production direction, actors and music will be from the broadcasting company staff. Time is donated and production costs are shared by the National Broadcasting Company.

Prize Offered for Paper on Glaucoma.—The National Society for the Prevention of Blindness announces that a prize of \$250 will be awarded for the most valuable original paper during 1943, adding to the existing knowledge about the diagnosis of early glaucoma. The award will be made by the Society with the guidance of an ophthalmological committee composed of Dr. Arnold Knapp, Dr. Manuel Uribe Troncoso and Dr. Mark J. Schoenberg.

Papers may be presented by any ophthalmologist, student in ophthalmology or research worker of the Western Hemisphere and may be written in English, French, German, Italian, Spanish or Portuguese, but those written in the last four languages should be accompanied by a translation in English. Papers should be in the office of the National Society for the Prevention of Blindness, 1790 Broadway, New York City, by September 15, 1943.

Highlights of the Hot Springs National Venereal Disease Conference, October 21-24, 1942.—Although there has been a steady decline in the venereal disease rates for the years 1939-1942, inclusive, the incidence of venereal diseases is still too high with a resultant loss of man-power to both the armed forces and industry: 57,000 selectees of the first 2,000,000 examined were rejected as unfit for military service because of venereal diseases; 300,000 workers engaged in war industries are infected with syphilis alone.

There is a definite responsibility for (1) Repression of prostitution; (2) Rehabilitation of the girls engaged in this activity; (3) Prevention of prostitution. More than 300 communities employing repression have shown a 75 per cent decrease in the work of the prostitute.

Treatment of early Syphilis: The high rate of delinquency in patients and the needs for rendering patients noninfectious have led to several schedules of treatment which embody the factors of therapeutic efficiency, limited toxicity and adequate margin of safety. The *Harry Eagle Plan*, a ten-week intensive schedule, is a compromise between the vexatious eighteen-month schedule, as now employed, and the dangerous 5-day drip method. The *Army Plan*, commonly referred to as G.O. 74, extends over a six-month period, during which 30

arsenicals and 16 Bismuth injections are given the patient. This schedule lends itself more easily to adoption by the private practitioner.

It should be mentioned that all plans, 10 day or less in duration, are experimental and dangerous. In all schedules of treatment careful examinations and frequent follow-up over a period of time are of utmost importance.

Legislation in 1943: Re Crippled Children.—The California Society for Crippled Children, as one of the original sponsors of the Crippled Children's Act (Health and Safety Code, Chapter 2, Article 2) passed by the Legislature in 1927, has always had a great interest in the work being done for crippled children through this Act by the State Department of Public Health. Our own observations confirmed by information received from the State Department of Public Health, make it obvious that certain changes and additions to the California law relating to crippled children are necessary at this time.

The proposed amendments to the Health and Safety Code which we intend to draw up and submit to the legislature are as follows:

1. An enabling provision specifically allowing the State Department of Public Health to accept financial assistance from the Federal funds made available through the Social Security Act for providing care for crippled children, and to coöperate with the Federal government and other agencies in developing this program.

2. An amendment to change the upper age limit for crippled children from eighteen to twenty-one years in order to conform to the Social Security Act.

3. An amendment allowing the State Board of Health to set minimum standards for the quality of care to be provided for children through this program.

4. An amendment to provide for a State appropriation for the purpose of providing care and administering the Crippled Children's Act. At the present time the program is supported approximately as follows:

Federal funds	59 per cent
County funds	39 per cent
State funds	2 per cent

We believe that a sufficient amount should be appropriated so that the combined State and County funds would at least equal 50 per cent of the entire program. This would require about \$50,000.00 per year.

New Psychiatric Service.—The San Francisco Department of Public Health, announces the opening of the psychiatric service of the San Francisco City Venereal Disease Clinic. The San Francisco City Clinic is located at 33 Hunt Street, San Francisco. The psychiatric service is established as a special field study project by the United States Public Health Service and offers the only psychiatric service of this type which has been established in direct conjunction with a venereal disease clinic in the United States.

The service will be based on an entirely individualized case study plan.

Those cases which show maladjustment will be referred to the psychiatric service.

No residence or financial requirements prevail in so far as the psychiatric service is concerned, and the service is in position to consider cases referred from outside sources. Arrangements will be made with various nonofficial agencies to provide funds in certain instances to carry out recommended psychiatric treatment plans. Attempts will be made to relocate the patients through coöperation of official and nonofficial agencies concerned.

The medical director of the San Francisco City Clinic

is the Chief of the Division of Venereal Diseases, Dr. Richard A. Koch. The Director of the Psychiatric Service of the clinic is Dr. Ernest G. Lion, who is instructor of psychiatry at the Stanford University School of Medicine. The personnel of the psychiatric service will consist of the psychiatrist, a chief psychiatric social worker, an assistant psychiatric social worker, and two clerks.

Sigismund Shultz Goldwater, M.D.—Dr. Sigismund Schultz Goldwater, Commissioner of Health of the City of New York in 1914-15, died in his sixty-ninth year at Mount Sinai Hospital, on October 22. To him was largely due the credit for the rehabilitation of the hospital system of the City of New York. While Commissioner of Hospitals, he helped to plan and supervise the construction of Welfare Hospital for patients with chronic diseases. Always a forceful character, he fought continually for progressive medicine and for improvement in hospital construction. At the time of his death he was an advisory construction expert for 156 hospitals in United States, Canada, Newfoundland, and British Columbia. He was not only a physician but a registered architect and an honorary member of the American Institute of Architects as well.

From 1934 to 1940, Dr. Goldwater was Commissioner of Hospitals, and upon his retirement in 1940, he became president of the Associated Hospital Service. He established the community ward plan for medical service. He had held honorary and official positions and had written extensively, particularly in the fields of hospital construction and public health service. At various times he had been president of the American Hospital Association, chairman of the Council on Community Relations and Administrative Practice, and a member of the editorial board of the *Modern Hospital*.

By his death, the Medical Society of the State of New York has lost one of its most distinguished members and the profession of medicine a valiant fighter for progress.

Research Grants to Stanford Medical School.

Research grants amounting to more than \$5 000 have recently been received by Stanford University in support of tropical disease studies being carried on by the University.

E. P. Mumford, research associate, is directing the Stanford research project which is an investigation of the geographical distribution of insects and other disease carriers, and of the parasites of man in relation to the war and its aftermath. The study is being made with special emphasis on the Pacific islands with which Mr. Mumford has been concerned in his research at Stanford since 1939.

Recent grants for the tropical disease research include \$4 000 from the Josiah Macy, Jr. Foundation \$850 from the Carnegie Corporation of New York \$400 from the National Academy of Sciences, and \$200 from the May Esther Bedford Fund, Inc., of Connecticut.

Other subscribers to this coöperative project at Stanford are the Higher Studies Fund at Oxford the British Association for the Advancement of Science, the Ella Sachs Plotz Foundation, and the Viking Fund.

Mr. Mumford recently published two papers on malaria and the plague in the Pacific, and is now at work on similar articles on parasitological problems of the Pacific in relation to the war and its aftermath and on diseases and their carriers in the Japanese mandated islands. The Stanford research associate is also preparing a brief manual on the distribution of tropical diseases and their carriers. A more comprehensive scientific work, to be

prepared later, will be of value to post-war reconstruction in areas of increasing strategic and commercial importance to the United States.

Allergy: Fifth Annual Forum.—This international postgraduate society will meet in the Hotel Statler in Cleveland, Ohio, the week end of January 9th and 10th, 1943. This Forum will offer a most intensive presentation both the new and the old in Allergy. The meeting will be characterized by its use of all the various types of instruction. Formal lectures, special talks, dry clinics, study groups, moving pictures, Kodachromes, panel discussions, ending with an "Information on Allergy, Please," will all be used to teach the physicians of the United States and Canada. Not only will specialists in this new field of Internal Medicine gather but also those whose interests are in allied fields of medicine will be welcome, for in war time every physician is called upon to advise and treat allergic patients. This is especially true of those in Internal Medicine, Diseases of Children, Diseases of the Skin, Diseases of the Eye, Diseases of the Nose and Throat, as well as those engaged in basic research in Immunology. A course in Immunology as it applies to Allergy will be given the week before by Dr. Eckers to a limited number of physicians and associates. Any physician interested in either or both of the foregoing is invited to write Dr. Jonathan Forman, 956 Bryden Road, Columbus, Ohio, for copies of the printed program and registration blanks.

Among the 58 Allergists participating in the program are many of the leaders in this field. Arthur Coca, M. D., of New York, will receive the Forum's Gold Medal for his outstanding contributions to the subject and will give the Forum's annual lecture on Allergy on Sunday afternoon.

Kenny Method Course Now in 6 Centers.—The fact that 1942 has been a light year for infantile paralysis has allowed the country to change over with a minimum of difficulty from the older method of treatment of the disease, particularly in the early stages, to the Kenny method. Up to the end of the first week of October there had been but 2834 cases reported in all of the United States. This is in comparison with 6850 for 1941 and 6918 for 1940 during the same period. It would have been totally impossible to supply nurses and physical therapy technicians trained in the Kenny method for an additional 4000 or more cases. As it is, in many parts of the country only insufficiently trained persons or those with no training in this method had to do the best they could.

Training facilities have been established by the National Foundation as rapidly as possible. Today doctors, nurses and physical therapists can go to any one of six places and receive good instruction. It is no longer necessary for everyone to go to the University of Minnesota. While Miss Kenny and her Australian assistants work only at that institution, each of the other places has trained personnel, associated with excellent educational institutions, in charge of the courses.

Aided by the Foundation, teaching programs are conducted at the following places, and information as to costs, dates of courses and admission policies can be secured directly from these schools and universities:

School of Health (Women)
Stanford University, California
Catherine Worthingham, Director
Children's Hospital Society
University of Southern California, Los Angeles
Lily Graham, Technical Director, School of Physical Therapy

University of Minnesota, Minneapolis
Director, Center for Continuation Study

Northwestern University Medical School, Chicago
Dr. John S. Coulter, Chairman, Department of Physical Therapy

D. T. Watson School of Physiotherapy, Leetsdale, Pennsylvania
Dr. Jessie Wright, Director

Physical Therapy Postgraduate School
Georgia Warm Springs Foundation
Dr. Robert L. Bennett, Director.

Virus of Infantile Paralysis: How It Enters the Body.—That the dreaded infantile paralysis virus may enter the body through the nerves of the mouth has been demonstrated by medical research at the Stanford University School of Medicine.

This is the first conclusive evidence of poliomyelitis infection by mouth in the early, preparalytic stage. Other suspected portals have been the nose and the intestinal tract.

"It would appear that the mouth and pharynx are readily vulnerable to penetration by the virus," Dr. Harold K. Faber, Stanford professor of pediatrics, and his assistant, Rosalie J. Silverberg, write in the current issue of "Science."

This does not exclude other possible portals of entry he emphasizes, but points out that "it is pertinent to note that the very frequent occurrence of headaches, vomiting, neck pains, and other symptoms in the preparalytic stage of the human disease strongly suggest early involvement of the brain stem which is better accounted for by entry through the mouth and pharynx than from the more distant intestines."

In Dr. Faber's research, the nerves of smell were excluded as a possible pathway by spraying the nasal passages with zinc sulphate. The animal had previously been fed virus in capsules and given an enema containing virus, both without producing the disease. However, when the mouth was sprayed with virus, unmistakable signs of the disease appeared within five days, although actual paralysis had not yet occurred. Microscopic evidences of infection were traced from the mouth along the course of the nerves of sensation and taste into the nerve ganglia, or relay stations, which lie outside the brain. The infection was also found just beginning to extend beyond these into the medulla oblongata, the lowest part of the brain which connects the brain with the spinal cord.

The discovery is considered important because the mouth is the first surface to be exposed to food and drink contaminated with virus, and, especially in the case of children, to fingers similarly contaminated and put in the mouth.

"In times of epidemic, special precautions suggested by these facts would be in order and might be of considerable preventive value," says the Stanford pediatrician.

Faulty Posture May Cause Maladies.—Certain symptoms of heart, bronchial and lung trouble may disappear if posture is corrected, according to Dr. William J. Kerr, Professor of Medicine at the University of California Medical School.

Observation of more than 300 cases at the Medical Center during a five-year period, declared Dr. Kerr, has led to the conclusion that many patients showing girth-obesity or having a relaxed abdominal wall may be relieved of anginal pains or pulmonary symptoms by means of a properly-fitted elastic abdominal belt. Acting as a means of artificial respiration, he explained, this aids in restoring the function of the diaphragm.—*U. C. Clip Sheet.*

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Are Doctors Being Hoarded?

There is a growing—and justified—concern over the draining of medical men out of civilian life into the armed services. The latest and most outspoken evidence of this concern was the preliminary report released by a senate labor subcommittee.

That report charged that "haphazard recruiting of doctors has led to a tremendous, unnecessary overmilitarization of the doctor supply at the expense of the civilian population" and warned that unless this "hoarding and freezing and unused doctors in the armed forces" is halted the nation faces serious consequences in civilian health.

It is a problem which warrants the most careful study. No one, of course, would argue that the armed services should not have all the doctors needed to maintain the health of the men at the highest level. But there is good reason to question seriously if as many doctors are needed as the army and navy believe.

The senate subcommittee report said the army and navy hope to maintain a ratio of approximately one doctor for every 100 men. For noncombat service that seems all out of proportion. Men in the armed services are the cream of the crop from a physical standpoint and should on the average require far less medical attention than the civilian population, yet the ratio of doctors in the civilian population prior to the war was about one to every 1,100 individuals—including not just young, healthy males, but children, old folks, women in pregnancy, the chronically ill and crippled.

The committee report said we had in the nation about 120,000 "medical effectives" and that one-third of them are already in the armed services, with another third scheduled to be called under the present army-navy program.

That is a dangerous situation, and for all we recognize the great importance of maintaining health in the armed services, we must (and the army and navy must) recognize the almost equal importance of maintaining health on the civilian front. Illness and breakdowns in health on the home front could wreck our march to victory by crippling war production just as surely as it could wreck it by crippling our military forces.

It has been reported that doctors in many of our army camps handle an average of three and a half patients a day. Anyone who has talked to doctors in the services knows that many of them feel their time is being wasted. One told this writer that all he did at a camp was "paint throats and hand out aspirin."

It's time for a careful restudy of our armed forces' medical needs. There should be one basis of medical staffing for men in noncombat areas and another basis for staffing in actual combat zones.

Certainly there is no need to build up a huge medical staff merely in anticipation of combat. A doctor doesn't need lengthy training to prepare himself for service with the army or navy. A month's time getting used to wearing a uniform and learning military routine should be ample. Why not call doctors into the service, give them such preliminary training and then release them to go back into private practice until there is actual need for their services?—*Salt Lake City Telegram*, November 9.

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Public Will Always Get What It Pays For

During the past few weeks there has been much publicity in regard to a low cost medical care insurance plan for the lower income farm families. Those affected by such a plan are entitled to know its details. Publishing of the details, however, does not mean endorsement of that program. Individuals or groups get in this world just what they are willing to pay for. That applies to services of individuals in the medical, legal or engineering worlds as well as to the materials that are used in the economic life. If the individual or group places a minor amount as a limit to be paid per yard of material, that material will not be pure silk or linen.

The medical profession has forgotten to collect as much as it has collected in caring for low income or destitute people. None have ever been denied the services of a reputable physician or surgeon in an hour of real need.

In the medical world, just as in any other economic work of life, training, ability, constant study, experience and devotion to work gauge the success upon which the value of services are based. When there shall cease to be a reward for effort, that effort shall cease and humanity will pay the penalty.

Utopia is not for this world and the more quickly the average individual learns this the more quickly will be benefit, mentally, physically and financially.—*Madera Tribune and Mercury*, November 12.

Solution for Doctors' Plight

More and more members of the medical profession are going into military service every day.

Young doctors just out of medical school, doctors who have barely established themselves in the community, and long established men who would soon begin to shift the burden of their practice to new partners, are donning uniforms.

For the medical people remaining at home, the task has become gigantic. But, one and all, they are grimly determined that essential medical care will be provided for civilians.

There are many ways in which the layman can help in this medical crisis. He can guard his own physical well-being by keeping regular hours and eating and sleeping properly. He can be tolerant if he is kept waiting for an appointment. And he should follow fully the advice of his doctor in order to return himself to full usefulness as soon as possible.

The small number of doctors left in Alameda have pledged themselves to take good care of our civilian needs but they can only fulfill their promise if they have the cooperation of every Alameda resident.

It stands to reason that there are not enough doctors still in Alameda to personally answer every sick call and interview every person who visits their offices.

The number of doctors in this city is rapidly diminishing. But the population is increasing by leaps and bounds and, therefore, the number of sick calls is mounting constantly.

Local doctors are carrying a tremendous burden and it will only be reduced if every citizen does his share.

Alamedans should guard their health now more closely than ever before. They should not call a doctor to their home unless it is absolutely essential. They should remember that in cases of minor illness, doctors and their nurses can properly pursue their duties by prescribing for the patient over the telephone.

If everyone keeps these things in mind, doctors will be able to carry on with the least possible trouble.

Alamedans must pull together. Don't summon your doctor to your house unless he is urgently needed. He can prescribe for a number of ills over the telephone—and will do so happily.—*Alameda Times-Star*, November 10.

* * *

Do Your Part to Help Save Doctors' Time

About one out of every three doctors practicing medicine in the United States is now in the armed services. It may not be long when this will be increased to one of every two. Those who are left tend to be the older and less robust, consequently those least able to carry heavy additional burdens of practice. Patient cooperation is a necessity for effective medical care during the remainder of the war.

Every individual who is old enough should learn first aid as taught in Red Cross classes and by Boy and Girl Scouts. Every person should learn how to eat intelligently, so that health may be maintained. Wise use of shelter and clothing should help to cut down colds, pneumonia and other results of exposure and chilling.

Look Ahead

All persons should procure for themselves or for their children the immunizations against communicable diseases which are devised by medical and public health authorities; these include small pox vaccination for everybody not successfully vaccinated within five years, diphtheria prevention for all children at the age of eight months, typhoid vaccination for all in certain localities, and under special circumstances as advised by the doctor, protective inoculations against whooping cough, scarlet fever, lockjaw and yellow fever.

Every one should learn the signs which indicate serious illness: unconsciousness, drowsiness or stupor; excessive excitement, irrational conduct, high or persistent fever, severe pain, persistent mild pain; "shock" or collapse; appearance of blood in bodily discharges; abnormal growth or swellings; and "upset" which does not show signs of improvement in 24 hours. These signs do not always indicate serious disease, but they do constitute reason for calling a doctor to be sure what they mean. In any case of uncertainty call the doctor; give the patient the benefit of the doubt.

Call in Morning

When calling the doctor call him early in the morning during his office hours or at noon so he can plan his calls with the least amount of travel and time. Go to him whenever possible instead of asking him to come to you. If he must come to you give him as good an idea as possible what sort of illness he may expect

to find. In anticipation of his departure for military service ask him what doctors he recommends; if he has gone call his home or office and ask if he has left such recommendations.

Hospitals are having many hard war problems, too. You can help by using hospitals only as your doctor advises.—San Francisco News, November 10.

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Behind the News: With Arthur Caylor Comments Concerning Kaiser Hospitals

The battle Henry J. Kaiser has been enjoying with the doctors of Portland may have repercussions that will affect many San Franciscans—already hit by a constantly worsening doctor-nurse-hospital shortage. For the Kaiser plan to provide "socialized medicine" to workers and their families already has gone up to the American Medical Association. The reaction of that body, my men report, may have much to do with the methods whereby any attempt is made to provide wartime medical service to civilians here.

It wasn't alone Kaiser's intention to provide medical service to their families as well as to the men which made the Portland doctors see red. Part of their anger was due to the fact that—at a time when they couldn't get a new gadget for existing hospitals—Kaiser flashed a shiny new hospital on them that was full of chromium, steel, copper and other forbidden metals. Where the doctors couldn't get instruments, it was evident that Kaiser could. His hospital even included a maternity ward, although at the time it was planned the shipyards weren't using any pregnant welders.

The reaction of the doctors was a bit swifter and hotter than that of an ordinary Joe Blow who walks into the office of some peanut official and finds he's making a career of the war. The office is full of thick carpets, steel desks, metal filing cabinets, extra-fancy lights, and other things the common people either can't have or soon won't be able to get. It makes the gorge rise, doesn't it?

Dope is, however, that the A.M.A. won't let anger get the better of its judgment. Some of its top men insist unusual steps must be taken to meet the emergency. If that involves doing some things the Kaiser way the doctors will do those things the Kaiser way.—San Francisco News, November 26.

* * *

'War Heart' Greatest Menace, Doctors Say

In a dim amphitheater at the University of California Hospital where the murals on the walls depict the progress of surgery since the days when a "surgeon was a dentist," 200 doctors from six states met on November 6, to talk over the problems that face the medical profession, mobilized for wartime duty.

And the problems, they agreed, were these:

A "war heart" is the greatest menace that faces a civilian population.

The scarceness of doctors is reaching alarming proportions.

The man on the street must calm down and the skitish race to live 24 hours in every day must be stopped.

Don't call your doctor unless you need him on an essential duty call.

The "red tape" of the Army, which called into service all medical men of what is termed a "fighting age," is cumbersome and binds doctors, vitally needed for civilians, to waiting three months before they can be used on hospitalization cases.

Nervousness Cited

The increase of public nervousness, which leads to "war hearts" is a potential Axis asset, and if not curbed will develop into cardiac disorders the medical profession cannot meet because it doesn't know how.

Those were the startling statements given at the 13th annual postgraduate symposium on heart disease, held in the gray-white University of California Hospital, where men from the sparse areas of Arizona, Nevada, Washington and California mingled with the surgeons and specialists on health from the cities.

When the assembly, which is affiliated with the American Heart and California Heart Associations, opened yesterday, Dr. T. Duckett Jones, nationally known expert on cardiac disorders, professor at the Harvard Medical School, warned sternly that "while the public is more tolerant today than a few months ago, it must realize that 100 per cent of intellectual consideration is worth 100 per cent of medical care."

"Schools are the greatest source of localities that cause the spread of streptococcus infections which lead to cardiac disorders," he said, nodding his head for emphasis. "If parents would only realize that it is better to keep

a child who is coughing out of school and if the schools only realized that thinking is more important than attendance—there's the answer to health."

An expert on rheumatic fever, which constitutes one-third of all cardiac diseases and is particularly prevalent in San Francisco among children, Dr. Jones told the assembled surgeons in the theater of the hospital that "this is our greatest killer and the only answer rests in adequate housing conditions, which each patient may be alone for the rest and quiet that is necessary for cure.

Must Take Rest

"Public nervousness is increasing due to uncertain conditions," he said, "but must be stopped by the individual taking a few hours of rest or else we face a population that is jitterish and vulnerable to heart rheumatism that results from that condition."

He said he had noted a particularly noticeable increase since the war broke out and urged that the "problems of the heart be met by community action."

The meetings began yesterday and will continue today and tomorrow, all devoted to technical clinical discussions of heart ailments, and held under the direction of Dr. J. K. Lewis, chairman; Dr. Dorothy Atkinson, Dr. Charles A. Noble, Marjorie Edwards and others of the Heart Committee.—San Francisco News, November 6.

* * *

A.M.A. Fights Trust Charge as Improper

Medicine a Profession, Not Trade, High Court Told

Washington, Dec. 11.—Counsel for the American Medical Association told the Supreme Court today that its conviction under an anti-trust indictment was improper because doctors practice a profession, not a trade.

The Government argued, however, that the Association had carried on activities aimed at group health association "principally for economic reasons" and that the Sherman law therefore applied.

Denies Contention

Seth W. Richardson, Washington attorney for the Association, asserted that the 1890 Sherman Act prohibited conspiracies in "restraint of trade" and that this was the first case in which "anyone suggested that the field of learned professions should be considered as a trade."

The attorney contended that restraint must be "commercial in its operation" to be prosecuted under the anti-trust law and that the Supreme Court had so held.

Validity of the conviction of the Association and an affiliate, the Medical Society of the District of Columbia, was defended by John Henry Lewin, special assistant to the Attorney General. He asserted that the organizations had attempted to destroy Group Health Association, Inc., described as a nonprofit cooperative association of Government employees in the District of Columbia.

Fined \$2,500

They were convicted in the United States District Court here and the national association was fined \$2,500 and the local society \$1,500.

Arguments will be resumed Monday by Thurman Arnold, assistant Attorney General in charge of anti-trust law enforcement, and William E. Leahy, another Washington attorney for the organizations.

Lewis said the indictment alleged that "A.M.A. has long been opposed to the group practice of medicine on a risk sharing, prepayment basis—the basis upon which group health provided medical care—and that this opposition has been principally for economic reasons and because A.M.A. fears the competition which this kind of practice offers to its doctor members, who practice on the customary fee for service basis."—San Francisco Examiner, December 12.

* * *

Idaho's Dilemma

The State of Idaho is between the horns of one of those dilemmas resulting when too many people make binding promises, but without unity of objective. The same voters elected lawmakers from both parties pledged to cut State expenses approved also a pension measure so liberal that its adoption could mean only an increase in State disbursements, and that would mean higher taxes.

Among the provisions of the pension bill are \$40 monthly cash allotments for all aged residents, eyeglasses and artificial limbs and teeth for those needing them, \$8 monthly medical care for every citizen 65 years of age or older, and \$100 burial costs for every pensioned person.

We do not know how things will work out in Idaho. But there is the precedent provided by Colorado. It will be recalled that the voters in that state approved a grandly liberal pension bill that simply had to be repudi-

ated for the very practical reason that there was not the money available for making good on the plan.—Palo Alto Times, November 20.

* * *

San Diego Hearing on Liberalizing Hospital Rules

San Diego—Liberalization of present county hospital rules to permit admission of any patient needing emergency hospitalization and for care by any licensed surgeon or physician, will be discussed at a hearing before the county supervisors November 9.

The county welfare department hospital admissions committee submitted a recommendation to the supervisors Monday urging changes in the present rules to meet wartime conditions.

The committee recommended that "in this emergency any licensed physician and surgeon may enter a pay patient into the county hospital as in any accredited private hospital subject to county hospital rules."

Supervisor Dean Howell said that before he voted to accept the committee's recommendations, he would like to hear expressions of private physicians and representatives of medical institutions as to the practicability of modifying the hospital rules. Dr. B. A. Adams, county hospital superintendent, also will be asked to attend the hearing.

Howell's views were concurred by the board. . . .—Oceanside Blade-Tribune, October 20.

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Pension Law Stumps Idaho

Liberal Measure, Voted by People, Threatens Headaches for Taxpayers

Boise, Idaho, November 17—(AP.)—Artificial limbs and teeth, eyeglasses and \$40 cash per month are promised Idaho's aged residents in the State's new pension act.

The law, which also provides for \$8 in medical care monthly for each citizen 65 or older and \$100 per person burial costs, threatens plenty of headaches for the State's legislators and taxpayers.

Approved by popular vote in the recent election, opponents call it one of the most liberal pension measures in the nation and assert it might cost as much as \$5,250,000 a year.

Members of the new General Assembly meeting in January already are wondering how they'll raise money to pay it, in the face of prelection vows by both parties to cut expenses.

Legislators have at least three courses open: refuse to appropriate funds, amend or repeal the act, or boost tax revenues.—Los Angeles Times, November 18.

* * *

Dorothy Thompson's Views on Medical Set-Up in the Future

Excerpt follows:

I submit we won't. I submit that at no distant date after this war is over some future Donald Nelson will arise and say to the National Association of Manufacturers, who by that time will have gotten over the shock:

"Gentlemen, I am pleased to report that we have within the last 12 months abolished one-third of all the slums, urban and rural, in the United States. We are behind our program, however, and are not yet using our resources to the fullest.

"Our program for the next year includes the perfection of a hospital network that will not leave a community without the most modern facilities for medical care. The decentralization of industries, with a view to bringing the factory to the farm, instead of the farm to the factory, is making great progress.

"I thank you, and the American farmer and worker, for the splendid vision and coöperation that began the day after Pearl Harbor and has proceeded uninterruptedly ever since."—San Francisco Chronicle, December 11.

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'Child Welfare Problem Grave But State Has Forged Ahead'

Federal Bureau Chief Here, Says There's Help in Sight from Congress

While conceding that California has a serious child welfare problem, Katherine Lenroot, chief of the U. S. Children's Bureau, in San Francisco, on November 9th, said that "this state has gone far in laying the foundation of care for children in war time."

Miss Lenroot, in San Francisco for a series of meetings with local child welfare authorities, declared that welfare problems are greatest in areas where there have been large increases of industrial population and where doctors, nurses and social workers have been drawn off for war service elsewhere.

She said that to ease the situation, a bill is pending in Congress which will provide additional funds for child care services through the Social Security Act.

"These funds will strengthen the service for mothers and children in defense areas, both military and industrial," she explained. "Maternity and medical care of infants and children of service men will be expanded.

"They will also meet the special problems of neglect and delinquency and strengthen the community programs for possible evacuation of children in case of enemy attack. A large part of the added money will extend day care service for children of mothers working in war industries."

Miss Lenroot was the principal speaker at a luncheon meeting at the Bellevue Hotel, sponsored by the Social Planning Committee of the Community Chest and representatives of social agencies in Oakland and Berkeley.—San Francisco News, November 9.

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'U. S. Hospital Crowding to Grow Worse' *'Bed Shortage Is Threat to Health of People at War'*

Chicago, November 12—(UP.)—The nation faces a serious hospital shortage, which in some cases already has forced the establishment of wards in corridors and the turning away of patients, E. K. Gubin, writer for "Hygeia" magazine, said today.

Mr. Gubin said indications are that conditions will be worse before remedial steps can be taken.

"To carry on the war effort successfully our workers must be healthy and stay healthy," Mr. Gubin wrote, but a shortage of facilities prevents adequate care for the sick.

"Eighty per cent of bed capacity is considered the maximum at which a hospital can operate efficiently," he said, "but according to Dr. Donald K. Freedman in a recent article in The Journal of the American Medical Association, many hospitals now continually have occupancy rates of 100 per cent or more."

Mr. Gubin said within the last 10 years more than 500 million dollars has been spent on hospital projects by the Federal Works Agency and others, but despite an increase of more than 100,000 beds, facilities remain inadequate.—San Francisco News, November 12.

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Extension of Sterilization Law Favored *Heads of 16 State Institutions Urge Inclusion of Sexual Psychopaths; Parole Peril Cited*

Sacramento, Nov. 12—An extension of California's sterilization program to include persons adjudged by courts to be psychopathic delinquents and sexual psychopaths was recommended today at a conference of heads of sixteen State institutions.

Under the present law governing State insane asylums and feeble-minded homes, the State can sterilize only persons adjudged by the courts to be feeble-minded or to be afflicted with certain types of insanity.

Seek Job Waivers

Looking forward to the legislative session next January, institutions heads also recommended that residence requirements be waived on all State civil service jobs involving institutions, and suggested that legislation to provide a minimum commitment for alcoholic patients at State hospitals be provided by law.

The extension of the sterilization program would require specific legislation, said Dr. F. O. Butler, acting director of institutions, because the attorney general's office has held that the present sterilization program can not legally include psychopathic delinquents or sexual psychopaths.

"There may be some public criticism of our action (in recommending extension of sterilization)," Doctor Butler said, "but we must face it. Psychopathic and mentally defective delinquents and sexual psychopaths should not be turned loose on society in their present state."

Peril of Parole

Dr. R. B. Toller, superintendent of the Mendocino State Hospital, urged legislation permitting sterilization of sexual psychopaths and said it is virtually impossible to keep such patients in State institutions for the rest of their lives.

"Many will be released on parole," he said, "and there is no way of knowing whether they will repeat their acts."

Many persons benefited by the expanded sterilization program can never be cured of their defects by hospital treatment, said Dr. G. Max Webster, superintendent of Patton State Hospital.

"They are born that way," he said, "and will never be any different."—San Francisco Examiner, November 13.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

San Francisco

Bill For Medical Services as a Preferred Claim Against the Estate of a Decedent

Section 950 of the California Probate Code sets forth the order in which the debts of a decedent shall be paid out of the assets of his estate. Of interest to the medical profession is the fact that the "expenses of the last illness," which include a bill for medical services, is third in the order of payment, and by this section is given priority in payment over all debts of the decedent with the exception of expenses of administration and funeral expenses. The result of this section is that in the case of an insolvent estate, if there are assets owned by the decedent at the time of his death sufficient to take care of the funeral expenses, normally the physician attending the decedent at his last illness will be paid for his services rendered.

Recent inquiries received by the writer call attention to the fact that there is a conflict between the above mentioned section of the California Probate Code and the laws of the United States, in that the state statute gives the expenses of the last illness of the decedent preference over practically all debts, including those having preference by the laws of the United States.

The question as to whether a bill for medical services rendered in connection with the last illness of the decedent should be paid prior to debts due the United States will arise whenever the assets in the estate of a decedent are not sufficient to pay both claims. In such event, it is necessary to resolve the conflict between the above mentioned state statute and Title 31, United States Code Annotated, Sec. 191, which provides in part as follows:

"Whenever any person indebted to the United States is insolvent or whenever the estate of any deceased debtor in the hands of the executor or administrator is insufficient to pay all the debts due from the deceased, the debts due to the United States shall be first satisfied; . . ."

For example, a claim of the United States government against a decedent for unpaid taxes would constitute a debt due to the United States from the decedent and by the terms of this section of the United States Code must be satisfied before any of the other debts of the decedent are paid. In the event there were not sufficient funds available in the hands of the executor or administrator of the decedent's estate to pay both expenses of the last illness and any taxes owing by the decedent to the United States, the physician's bill would remain unpaid. Such a result would be in direct conflict with the state statute.

The Superior Court of the State of California, in Los Angeles County, recently was presented with such a problem. At the time of the death of

the decedent, there were owing by said decedent social security and unemployment taxes to the United States and there were not sufficient assets in the estate to pay the full amount of these claims. In addition, there was a bill for medical services rendered in connection with the last illness of the deceased due to the physician who had attended during the last illness. It was necessary for the court to decide whether to give effect to the state statute which would require the payment of the physician's bill or to follow the terms of the federal statute which gave the claim for social security and unemployment taxes priority in payment over all other debts of decedent. The Court ruled that Title 31, Sec. 191, of the United States Code governed and that the claim for taxes must be paid. The result of such determination was that the physician received no compensation for his services.

Apparently, there are no decisions by any higher court in the State of California directly interpreting the conflict between the provisions of our statute and the above quoted section of the United States Code, but, in the opinion of the writer, the decision of the Superior Court, in Los Angeles County, was correct. It has been held, in other jurisdictions, that the priority given to the United States by this section cannot be impaired and that this section must prevail over any state law providing to the contrary.

In *Estate of Barriero*, 125 Cal. App. 153, the District Court of the State of California inferred that they would hold any claim for income taxes due to the United States to have priority over all other debts of the decedent. This would indicate unfortunately that the decision of the Superior Court of Los Angeles County was correct in holding that a claim of the United States for social security and unemployment taxes accruing during the lifetime of the decedent should be afforded priority of payment over the claim of a physician for medical services rendered the decedent in connection with his last illness. The attitude of the courts of our state with respect to payment of taxes is illustrated by the following quotation from *Estate of Morris*, 37 Cal. (2d) 155, involving a claim due for state sales taxes. In discussing and approving decisions of the Federal Courts giving claims for taxes priority in payment over other claims against the estate of a decedent, the State Supreme Court said:

"These cases proceed upon the theory that the maintenance of the government and the public welfare are so dependent upon the collection of taxes that payment should have precedence over all other claims and it is thought that taxes levied for the support of government are founded upon a higher obligation than other demands."

Recognizing the serious consequences to the medical profession, it is nevertheless only logical to conclude that the collection of taxes lawfully imposed by the federal government cannot be made dependent upon state law in such manner that a state statute could give priority to the payment of a physician's bill in preference to the payment of taxes owing by the decedent at the time of his death.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

LETTERS†

Concerning California Institutes on Wartime Industrial Health

(COPY)

ROBERT T. LEGGE, M. D.
Berkeley, California

Nov. 27, 1942.

Dear Doctor Kress:

As Chairman of the recently held Institutes on Wartime Industrial Health, I desire to thank you for the personal interest you have taken in these Institutes, the advice rendered, the great publicity, and the publication of the papers in CALIFORNIA AND WESTERN MEDICINE. It was a timely and a constructive contribution of the California Medical Association. I also read with much interest the editorials in the October number of the Proposed Section on Preventive and Industrial Medicine and Public Health. I am sure it will please the members of our profession who are in public life engaged in these fields.

With kindest regards,

Yours sincerely,

(Signed) ROBERT T. LEGGE, M. D.

* * *

San Francisco, December 1, 1942.

To the Editor:—With respect to the California Industrial Hygiene Institutes, I think we have hit upon a pattern here which can be used to great advantage for the physicians in this State. As soon as opportunity presents, I hope we can get together on similar programs in the near future.

I am keenly interested in the suggestion that we make a greater welcome for the public health physicians of the State in the California Medical Association. Please count on me for any assistance you may wish to further this splendid idea.

Sincerely yours,

(Signed) W. P. SHEPARD, M. D.

Concerning Social Hygiene Day: February 3, 1943

To the Editor:—Social Hygiene Day will take its battle stations throughout the country as in former years, despite the gasoline and rubber restrictions which are in force this year. Doctor Walter Clarke, Executive Director of the American Social Hygiene Association, in announcing the annual observance scheduled for Wednesday, February 3, 1943, said that this battle on the home front against venereal disease is nation-wide and does not depend upon transportation to rally its fighting forces.

Syphilis and gonorrhea are enemies which threaten us at home. They disable our men at the front, but their roots are on the home front.

During the first World War, there were 157,146 more new cases of syphilis and gonorrhea among United States soldiers, sailors and marines, Doctor Clarke explained, than there were wounds in battles. Total absences from duty due to this infection kept the equivalent of 20,600 men out of the fighting for a whole year, men trained for their country's service, men upon whom their country counted for its defense.

In terms of today's hard held fronts such a loss would mean the equivalent of the personnel required to man five huge aircraft carriers and nine destroyers. No axis enemy could be more destructive than this enemy whom we must defeat on health battle fronts within our own country. We do not need to suffer this loss and do not

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

need gas and tires to meet that enemy and to destroy him. We have the scientific weapons to prevent the spread of the venereal diseases. In war time the principal function of social hygiene organizations everywhere is to persuade every community to use these weapons effectively. Intelligent coöperation among the health and welfare agencies in every city and town will help stamp out venereal disease and thus help our armed forces to bring us victory on the battle fronts.

(Signed) AMERICAN SOCIAL HYGIENE ASSOCIATION.

Concerning B.M.I. Hospital at Las Vegas: F. E. Clough, M. D., Formerly of San Bernardino, in Charge

To the Editor:—In the B.M.I. Hospital, we aim:

To give to its patients the best medical care;

To do everything which will return the patient to health with the utmost expedition;

To do these things in the spirit of kindly, wholehearted personal service.

With these words emblazoned on a plaque, the new B.M.I. Hospital was opened for service Sunday, after a dedication ceremony in which patriotism, medical ethics, and the concern of modern industry for the welfare of its employees featured a simple, impressive ceremony.

The new hospital of "Basic Magnesium," at Las Vegas, though erected primarily to take care of accidents to employees and provide medical service for them, will also be open to families of project employees when need arises and, of course, only when space is available. Charges for these services will be commensurate with services performed, and will conform to rates prevailing in this locality. Physicians on the staff, making calls on patients, will also charge in accordance with rates governing in this area.

Relatively New in Industry

The big and important thing about the new hospital is that it represents something relatively new in American industry. Embodied in its physical structure and the apparatus and equipment which it houses, the hospital is a monument to the insistence of modern industry that the health and safety of employees is of vital importance.

Equipment the Latest

No industrial hospital in the world is better equipped to give high type hospital and medical service. In all departments the very latest equipment evolved by medical science has been installed. No pains and no money has been spared to guarantee that men and women on this project will have the best.

Very truly,

F. E. CLOUGH, M. D.

N. F. Sprague, D.O., Given U. C. Regent Post

Sacramento, Nov. 10—Gov. Culbert L. Olson today appointed Dr. Norman Frederick Sprague, Los Angeles osteopathic physician, to the board of regents of the University of California to fill the unexpired term of the late Garrett McInerney, San Francisco.

Dr. Sprague is managing director of the Wilshire hospital of Los Angeles, a member of the State board of health, and was appointed by Olson as a surgeon of Statewide reputation. His appointment, the first "lame duck" appointment made by Olson since his defeat for reelection, runs until March 1, 1952.—San Bernardino Sun, November 11.

Births Going Up

Birth statistics of the United States for 1941 reveal a birth rate of 18.8 against 17.9 the preceding year; a total of more than 2,500,000 babies born (greatest number since 1921's 2,600,000); and that births exceeded deaths by 1,090,000.—San Francisco News, December 7.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 12, December, 1917

EXCERPTS FROM EDITORIAL NOTES

Medical Patriotism and the State Society.—It has been iterated and shall be reiterated that patriotism consists in actions as well as words and, of the two, actions are the more important. From the beginning, American men of medicine have been noteworthy for their maintenance in vigor and purity of the institutions and ideals of their country. Nor have they fallen short in the present emergency. The response in California to the summons of the Army and Navy is enthusiastic and liberal. Our quota will be provided. There are, however, certain less public and obvious fashions of expressing and rendering patriotic service, and these must not be lost to attention. . . .

Hence comes the necessity now for the physician in California to assume his public rôle as he has not done heretofore. Hence the necessity for him to organize as he has not done before. Organization and efficient assumption of these public obligations by the medical profession are thus a definite and clear public duty. They are a necessary form of patriotic service. The doctor who conscientiously or of necessity is not in uniform, cannot escape this obligation. If he is neither in service nor in the organized ranks of his profession, then he is a slacker from the obligations of a public nature which rest on our profession today. The war is a trumpet call for every reputable physician to enroll in his local county medical society, and help direct and extend the useful functions of the State Society. . . .

More Medical Officers.—At the last meeting of the Council of National Defense, Medical Section, a complete list of the physicians in California who have entered the Medical Officers' Reserve Corps was presented. Their number totals to date 665 men. The entire number required from the State is 800. It is therefore apparent that there are approximately 135 men yet to volunteer for military service. . . .

How many physicians, you included, can sign their names legibly? How many can write a legible prescription? And if they can, how many actually do these things? It would surprise many a doctor to know the difficulty and legal penalties which not infrequently follow an unintelligible signature on the records of the secretary of the State Society and of the State Board of Medical Examiners. In the present day of typewriters, every communication for publication, and most for correspondence, should be typed, with good margin, double spaces and, above all, with a legible signature. Observe your handwriting objectively and see if it really is legible.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Diseases of War: Their Prevention, Control and Treatment (The Handling of Infectious Diseases in the Field)", by Major Lloyd L. Smith, Medical Corps, United States Army.—The diseases responsible for the greatest losses in war may be practically divided into two main groups: (a) those of

(Continued in Front Advertising Section, Page 10)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners, held in the Business and Professions Building, Sacramento, October 19 to 22, the following officers were elected for the ensuing year:

President—Percival Dolman, M. D., San Francisco.

Vice-President—George Thomason, M. D., Los Angeles.

Secretary-Treasurer—Charles B. Pinkham, M. D., San Francisco.

Dates for meetings, for the year 1943, will be as follows:

March 8 to 11, inc., Elks Club, Los Angeles.

July 12 to 15, inc., San Francisco.

Aug. 9 to 12, inc., Elks Club, Los Angeles.

Oct. 18 to 21, inc., Sacramento.

The following changes were made in the status of California licentiates, after hearing before the Board:

John Joseph L. Doyle, M. D., Certificate revoked Oct. 22, 1942.

Newton T. Enloe, M. D., on Oct. 20, 1942, placed on probation for a period of one year.

Thomas Flint, Jr., M. D., on Oct. 22, 1942, placed on probation for a period of five years.

Gordon Havstad, M. D., on Oct. 20, 1942, reprimanded.

George Carl H. McPheeters, M. D., on Oct. 22, 1942, revoked.

Chester D. Sewall, Revoked Oct. 20, 1942.

Philip John Murphy, M. D., was on Oct. 22, 1942, found guilty on Counts 1 and 2 of the Complaint and penalty was deferred to the Los Angeles meeting.

The certificate of Samuel D. Burgeson, M. D., revoked Oct. 19, 1937, was restored Oct. 22, 1942.

The following cases were continued for hearing to the Los Angeles meeting:

William E. Glaeser, M. D., Herbert B. MacRae, M. D., Charles Pius, M. D., William Walter Reich, M. D., Darrington Weaver, M. D., Charles Roy Wright, M. D.

Seventy-two applicants of various classes wrote the examination, including several graduates of foreign medical schools.

News

"Dr. R. H. Bean, D. C., a chiropractor with offices in the Forum Building, was booked in the city jail on a charge of violating the business and professions code by prescribing medicine for a patient. . . ." (Sacramento Bee, October 30, 1942.)

"F. M. Koyle, 65, a shipyard worker, was fined \$50 and placed on two years' probation, on a charge of practicing medicine without a license, in Oakland Police Court, yesterday. The charge was brought after an in-

(Continued in Front Advertising Section, Page 22)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



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Bequest Forms: Unto the Physicians' Benevolence Fund of the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of \$_____ for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of \$_____, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the County of _____, State of California, and more particularly described as follows, to-wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axel E. Anderson, Chairman, 1759 Fulton St., Fresno.

BOARD OF MEDICAL EXAMINERS

(Continued from Page 26)

charge of firing a gun within the city limits, and was fined \$10 by Judge Marshall Hickson. A complaint was issued against the doctor following some target practice at the home of Prince Stanislas Bielski, at 705 Ocean Front, September 27. Bullets landed on the beach among bathers, according to the complaint." (Santa Monica Outlook, October 7, 1942.)

"Claiming that there is no place in the armed forces for chiropractors, the International Chiropractors' Association has petitioned Maj. Gen. Director of the Selective Service System, to recommend deferment of all members of the profession, permitting them to serve on the home front 'where their skill can help in the maintenance of national health and welfare.' Announcement of this action was made here today by Dr. S. J. Francis, local representative of the association. The petition pointed out that members of the profession, holding master's degrees in chemistry and other subjects, conferred by state universities, are automatically eliminated from serving in their specialized fields, due to 'regulations written in the Selective Service Act by organized medicine.' The petition continues: 'Since the government has given medical doctors exclusive rights and privileges in the armed forces, and anyone even remotely identified with chiropractic is excluded from specialized service, we believe that members of the profession should be deferred. It is a reflection against sound common sense to compel a graduate chemist to enlist as a private, or to expect a man who has spent years in the study and practice of chiropractic to become a hospital orderly.'" (Santa Ana Register, September 25, 1942.)

"Dr. John Weber, former director of Ahwahnee Sanitarium, has been appointed Medical Director of the Medical Plan at the Douglas Aircraft Plant, in Long Beach. . . ." (Madera Tribune and Mercury, October 3, 1942.)

"Classified as 'potentially dangerous' by the Western Defense Command and Lieut. Gen. John L. DeWitt, 46 aliens and citizens, including a prominent Oakland physician and two Oakland shipbuilders, today were ordered out of the western combat zone. . . . Dr. Karl Joseph Deissler, physician, of 50 Sotelo Avenue, Piedmont, with offices at 357 Thirtieth St., formerly connected with the Mayo Clinic. . . . Dr. Deissler, who left three weeks ago for the middle west, was at one time personal physician to Fritz Wiedemann, former German consul in San Francisco. Although born in Germany, Doctor Deissler is a naturalized American citizen. Doctor Deissler came to the United States in 1930, and to Oakland in 1935, from the famed Mayo clinic. Since then he has made three trips to Germany. . . ." (Oakland Post-Inquirer, October 12, 1942.)

"Twenty additional law suits for a total of \$2058,925 damages, were filed in Superior Court yesterday by shipyard workers, complaining they suffered roentgen dermatitis—x-ray burns, while undergoing treatment for minor injuries. The new complaints, added to the 17 filed last Thursday, bring the total of damage claims up to \$3868,840. In three of the actions filed yesterday, the claimants plead that they have lost fingers by amputation due to the burns and that further amputations may be necessary in the near future. . . . Other suits were

(Continued on Page 30)



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Resident Clinicians

BOARD OF MEDICAL EXAMINERS

(Continued from Page 28)

filed principally on the complaints that the workers face possible amputation of hands, fingers or feet because these members were left too long exposed to x-ray equipment when they reported at a shipyard first-aid station for treatment for minor cuts and lacerations incurred during their work. . . . The action brought by Cook names as defendants the California Shipbuilding Corporation, Liberty Mutual Insurance Company, Dr. Isaiah Waterman, Dr. Robert Woodley Stellar and others identified only as John Does." (Los Angeles Times, October 24, 1942.) The 1942 directory of the Board of Medical Examiners, page 19, lists Isaiah J. Waterman as having his license revoked March 5, 1942.

"A San Francisco surgeon, who used to be a high

ranking medical officer in the German Army of World War I, yesterday was ordered to get out of San Francisco as a 'potentially dangerous' man. He is Dr. Hajo Peter Plagge, of 728 Twenty-second Street, and his name was one of three on a list of 'excludes' announced by the Army's Wartime Civilian Control Administration here. . . . In the files of Government and local agencies investigating the activities of aliens and suspected persons in the war effort, the name of Doctor Plagge is listed as a former member of the 'Friends of New Germany' and the notorious German-American Bund. He is also said to have been a close associate of Hermann Schwinn, erstwhile 'Pacific Coast Fuehrer' of the Bund. He was formerly on the staff of San Joaquin County General Hospital at Stockton. Yesterday Doctor Plagge said he will leave San Francisco within the ten days allowed by the Army's order. 'Five years ago,' he said, 'I gave up my membership in German societies. I do not

(Continued on Page 32)

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Accuracy
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Reliability

The Owl Drug Co

130 STORES ON THE PACIFIC COAST

BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

belong to anything now—except the good old United States.' . . ." (San Francisco Examiner, November 6, 1942.)

"John J. Burke, 54, seems to have a yen for the Army. According to authorities, he served a two-year term in the United States prison at Leavenworth, Kan., for impersonating an Army officer. Yesterday he was before Municipal Judge R. Morgan Galbreth for preliminary hearing on a petty theft charge involving his posing as a retired Army surgeon. Witnesses alleged that Burke gave several women, particularly widows with some funds, physical examinations at \$1.25 each, to see whether they were fitted for defense jobs." (Los Angeles Herald and Express, November 5, 1942.)

"Three counts of illegal voting preferred against Dr. William W. Reich, Berkeley physician, were dismissed yesterday by Superior Judge Edward J. Tyrrell, in Oakland. Dr. Reich told the court that in giving his place of birth as Independence, Mo., he had acted in good faith, and that he had believed this town to be his birthplace although it was subsequently discovered that he was born at Singapore and was therefore a British subject." (San Francisco Chronicle, November 6, 1942.)

Recent Licentiate: Board of Medical Examiners of the State of California.—Charles B. Pinkham, M. D., Secretary-Treasurer of the Board of Medical Examiners of the State of California, reports results of

(Continued on Page 33)

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Arthur C. Robbins, M.D.
John C. Kraushaar, M.D.

BOARD OF MEDICAL EXAMINERS

(Continued from Page 32)

the written examination held in Los Angeles, July 28, 29 and 30, inclusive, 1942. The examination for physicians and surgeons covered nine subjects and included ninety questions. An average of 75 per cent is required to pass. One hundred and twenty wrote the examination. Included in the applicants were several graduates of foreign medical schools.

The highest mark for physicians and surgeons (88-7/9 per cent) was made by John M. Masson, M. D., 1309 San Pablo Street, Los Angeles, California, a graduate of the Stanford University School of Medicine, June 14, 1942.

The following is a list of successful applicants:

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Los Angeles		
Artress, Frank Lynn	Coll. of Med. Evang.	'42
Loma Linda		
Baker, James Delmer	Coll. of Med. Evang.	'42
Bakersfield		
Barry, John William	Loyola U. Sch. of Med., Ill.	'41
Long Beach		
Beauchamp, Mark Louis	U. of Alberta Fac. of Med., Canada	'37
Los Angeles		
Birnbaum, Harold	U. of Calif. Med. Sch.	'42
Los Angeles		
Boyd, Robert Irving	Stanford U. Sch. of Med.	'42
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Bradshaw, Frederic William	U. of Oregon Med. Sch.	'41

(Continued on Page 34)

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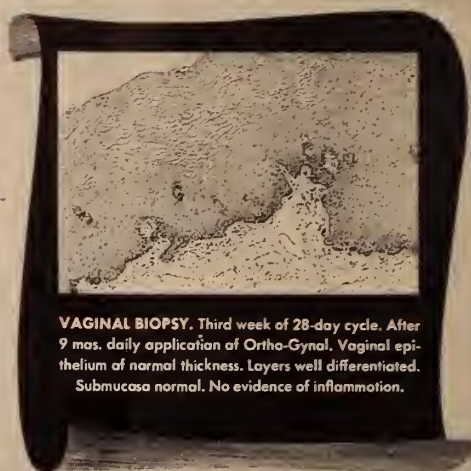
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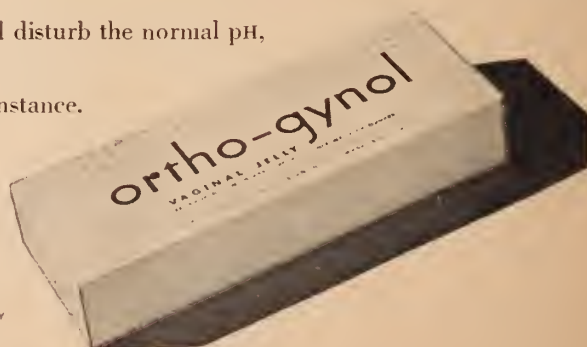
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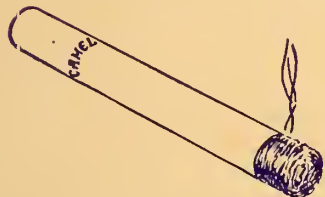
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Brückner, H.—Die Biochemie des Tabaks, 1936
The Military Surgeon, Vol. 89, No. 1, p. 5, July, 1941

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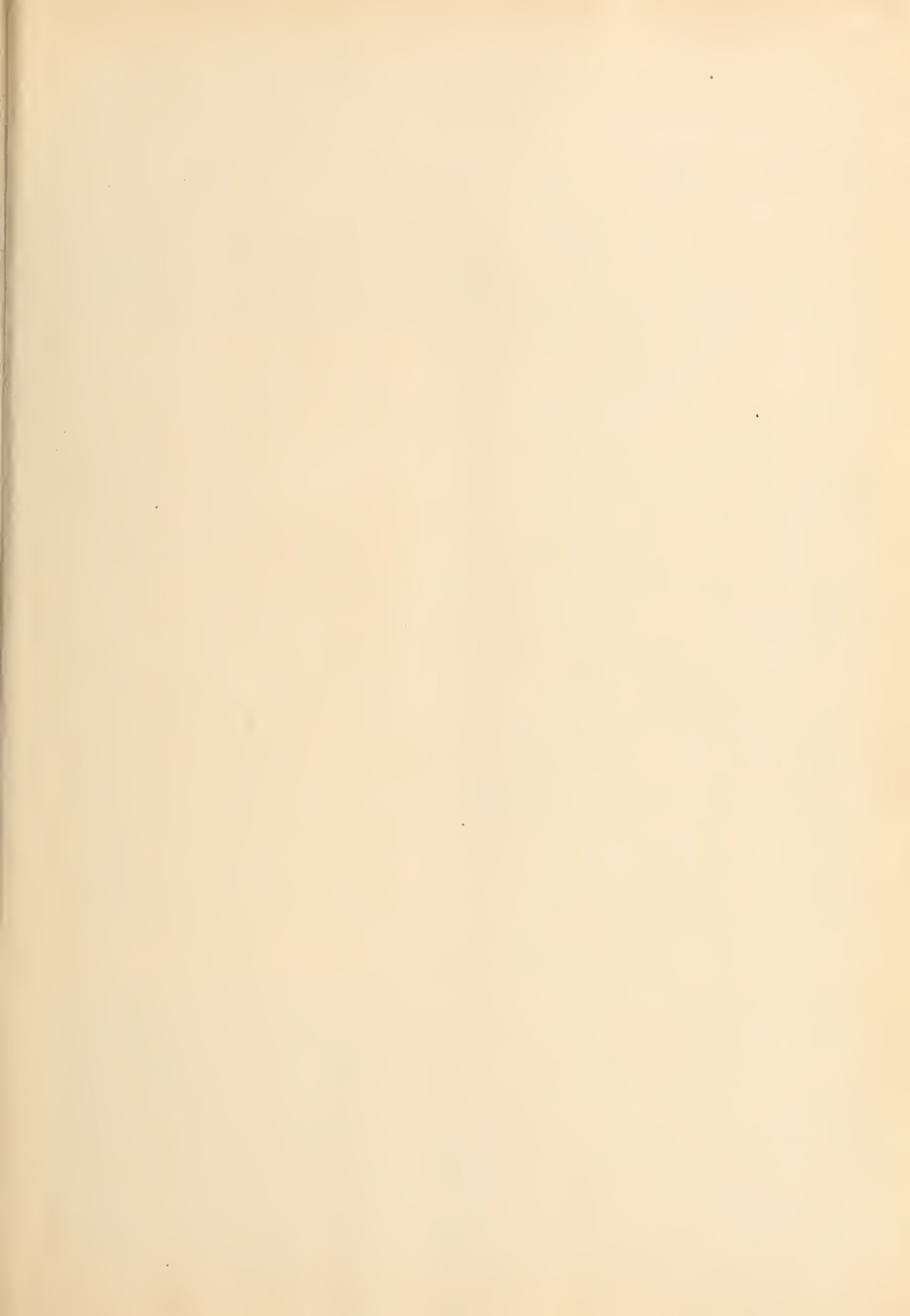
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